# Exhibit 44

# Maine Automobile Dealers Association Insurance Trust

## GROUP MEDICAL PLAN

March 1, 2015

030484

# INTRODUCTION

**The benefits and coverage described herein are provided through a trust fund established and funded by a group of employers.**

This Plan Document describes the benefits available to Plan Participants under the Maine Automobile Dealers Association Insurance Trust Group Medical Plan.

The benefits described in this Plan Document are those in effect as of March 1, 2015

Every attempt has been made to be informative about benefits available under the Plan and those areas where a benefit may be lost or denied.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the employer, Plan Administrator, Contract Administrator, and such other individuals as may be party to or associated with the Plan shall be guided solely by this Summary Plan Description, which is also the Plan Document. It is the intention of the Employer that this document will comply with the pertinent provisions of the Employee Retirement Income Security Act of 1974, as amended.

The Plan Administrator shall have full discretionary authority to interpret this Plan, its provisions and regulations with regard to eligibility, coverage, benefit entitlement, benefit determination and general administrative matters. The Plan Administrator's decisions will be binding on all Plan Participants and conclusive on all questions of coverage under this Plan, subject to the Plan Participant's appeal rights described later in the Plan Document.

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

The Maine Automobile Dealers Association Insurance Trust hopes and expects to be able to continue the Plan indefinitely but reserves the right to make changes in the Plan or to discontinue the Plan at any time. Should the Plan be terminated, Plan Participants will be notified at least ten (10) days in advance of the termination date. Any and all amendments to the Plan shall be in writing and shall be authorized by the signature of Thomas T. Brown, Jr., as President of the Plan Administrator, the Maine Automobile Dealers Association, Inc. or his designee.

# THE MADA HEALTH PLAN NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## USE AND DISCLOSURE OF HEALTH INFORMATION

The MADA Health Plan (the collective name for the Maine Automobile Dealers Association Insurance Trust Group Medical Plan and the Maine Automobile Dealers Association Insurance Trust Group Dental Plan) may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The MADA Health Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

**To Make or Obtain Payment**. The MADA Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the MADA Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

**To Conduct Health Care Operations**. The MADA Health Plan may use or disclose health information for its own operations to facilitate the administration of the MADA Health Plan and as necessary to provide coverage and services to all of the MADA Health Plan's participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.

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- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.

- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.

- Business planning and development, including cost management and planning related analyses and formulary development.

- Business management and general administrative activities of the MADA Health Plan, including customer service and resolution of internal grievances.

For example, the MADA Health Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

**For Treatment Alternatives**. The MADA Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health-Related Benefits and Services.** The MADA Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

**For Disclosure to the Plan Sponsor.** The MADA Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of the MADA Health Plan. In addition, the MADA Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The MADA Health Plan also may disclose to the plan sponsor information on whether you are participating in the MADA Health Plan.

**When Legally Required.** The MADA Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

**To Conduct Health Oversight Activities**. The MADA Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The MADA Health Plan, however, may not disclose your health information (unless otherwise required by law) if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

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**In Connection With Judicial and Administrative Proceedings**. As permitted or required by state law, the MADA Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the MADA Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes**. As permitted or required by state law, the MADA Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the MADA Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

**In the Event of a Serious Threat to Health or Safety**. The MADA Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the MADA Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions**. In certain circumstances, federal regulations require the MADA Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

**For Worker's Compensation**. The MADA Health Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

## AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the MADA Health Plan will not disclose your health information other than with your written authorization. If you authorize the MADA Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

## YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the MADA Health Plan maintains:

**Right to Request Restrictions**. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the MADA Health Plan's disclosure of your health information to someone involved in the payment for your care. However, the MADA Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the MADA Health Plan Privacy Officer at (207) 623-3882.

# THE MADA HEALTH PLAN NOTICE OF PRIVACY PRACTICES

**Right to Receive Confidential Communications**. You have the right to request that the MADA Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the MADA Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the MADA Health Plan Privacy Officer, Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882. The MADA Health Plan will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the MADA Health Plan Privacy Officer, Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882. If you request a copy of your health information, the MADA Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

**Right to Amend Your Health Information**. If you believe that your health information records are inaccurate or incomplete, you may request that the MADA Health Plan amend the records. That request may be made as long as the information is maintained by the MADA Health Plan. A request for an amendment of records must be made in writing to the MADA Health Plan Privacy Officer, Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882. The MADA Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the MADA Health Plan, if the health information you are requesting to amend is not part of the MADA Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the MADA Health Plan determines the records containing your health information are accurate and complete.

**Right to an Accounting**. You have the right to request a list of certain disclosures of your health information that the MADA Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the MADA Health Plan Privacy Officer, Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882. The request should specify the time period for which you are requesting the information, but may not start earlier than February 28, 2009. You have the right to receive an accounting of disclosures of protected health information made in the six years prior to the date on which the accounting is requested. Accounting requests may not be made for periods of time going back more than six (6) years. The MADA Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The MADA Health Plan will inform you in advance of the fee, if applicable.

# THE MADA HEALTH PLAN NOTICE OF PRIVACY PRACTICES

**Right to a Paper Copy of this Notice**. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a copy, please contact the MADA Health Plan Privacy Officer, Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882.

## DUTIES OF THE MADA HEALTH PLAN

The MADA Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The MADA Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. The MADA Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If it changes its policies and procedures, the MADA Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to submit complaints to the MADA Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the MADA Health Plan should be made in writing to the MADA Health Plan Privacy Officer, Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882. The MADA Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

## CONTACT PERSON

The MADA Health Plan has designated the MADA Health Plan Privacy Officer as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882.

## EFFECTIVE DATE

This Notice is effective March 1, 2015.

**IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT the MADA Health Plan Privacy Officer, Maine Automobile Dealers Association, 180 Civic Center Drive, P. O. Box 2667, Augusta, ME 04338-2667; (207)623-3882.**

# Table of Contents

# Section One
# General Information

The Maine Automobile Dealers Association Insurance Trust Group Medical Plan ("Plan") has been established and is maintained by the Maine Automobile Dealers Association Insurance Trust. Plan Participants may, upon written request, receive from the Plan Administrator information as to whether a particular employer is a Participating Trust Employer.

**Plan Name**
The Maine Automobile Dealers Association Insurance Trust Group Medical Plan.

**Plan Number**
The Plan Number for IRS reporting is: 501

**Plan Administrator**
The Maine Automobile Dealers Association, Inc.
180 Civic Center Drive
PO Box 2667
Augusta, ME 04338-2667
(207) 623-3882

**Plan Sponsor**
The Maine Automobile Dealers Association Insurance Trust
180 Civic Center Drive
PO Box 2667
Augusta, ME 04338-2667
(207) 623-3882

**Contact Person:** Thomas T. Brown, Jr.

**Plan Funding:** Plan Benefits are funded through the Maine Automobile Dealers Association Insurance Trust.

**Employer Identification Number (E.I.N.) Assigned to Sponsor by the IRS:** 01-0288347

**Type of Coverage Provided Under the Plan:** Group Medical Benefits

**Type of Administration**
Contract Administration by:
Anthem Blue Cross and Blue Shield
2 Gannett Drive
South Portland, ME 04106
(207) 822-7000

Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**Agent for Legal Service**

The agent for service of legal process is the Plan Administrator and service may be made at the above address.

**Contributions to the Plan**

Participating Trust Employers and Employees of Participating Trust Employers who are enrolled in the Plan contribute to the Plan.

**Plan Year**

The Plan Year commences on March 1 and ends February 28 (February 29 for leap years). (The calendar year is used for purposes of determining benefits provided under the Plan, including the application of deductibles, copayments, and coinsurance.)

**Reservation of Rights**

As sponsor of the Plan, the Trustees of the Maine Automobile Dealers Association Insurance Trust reserve the right to make changes at any time and from time to time in the terms of the Plan, including without limitation terms relating to eligibility, coverage, and benefits, and to discontinue or otherwise terminate the Plan or any part thereof at any time.

# Section Two
# Eligibility, Termination and Continuation of Coverage

## Eligibility

**Eligible Employees**

All regular, full-time employees of a Participating Trust Employer working at least 30 hours per week in the service of the Participating Trust Employer.

The Plan does not base eligibility on any of the following health status-related factors: medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

**The Waiting Period**

For all new employees of a Participating Trust Employer, the waiting period is the remaining portion of the calendar month in which you first began work at the Participating Trust Employer, and the entire following calendar month.

**Date of Eligibility**

For all new employees and their eligible dependents, the date of eligibility occurs upon completion of the waiting period. For all other employees and their eligible dependents, the date of eligibility is the date the eligibility requirements have been satisfied as described herein. New employees or newly eligible employees must submit their enrollment application within the initial enrollment period. Failure to do so will cause such persons to become **late enrollees** (see late enrollee page 7). The initial enrollment period is 30 days from the date of eligibility.

**The Effective Date of Coverage**

Participation in the Plan is effective on the first of the month next following the date of eligibility. For example, if you first began work January 1, 2004, your effective date of coverage would be March 1, 2004. If you first began work January 31, 2004, your effective date of coverage would still be March 1, 2004.

**Transfer Provision**

Covered employees who terminate from the employment of one Participating Trust Employer and become an employee of another Participating Trust Employer within 30 days of their termination date, and who timely apply, shall not have a break in coverage.

**Decisions Regarding Claims**

If you have a claim which has been partially or wholly denied, and you wish to question the claims decision, contact the Plan Administrator (named above), who will provide you with the reasons for the decision and the procedure to follow should you wish a full review of your claims. Please refer to the Benefit Determinations, Payments and Appeals section of the Plan Document for details.

**Misrepresentation**

If you make any misrepresentation or use fraudulent means in applying for coverage or filing a claim for benefits, your coverage will terminate under this Plan.

## Beginning Coverage

Before your coverage begins, your application must be accepted and you must pay for your coverage. The Participating Trust Employer acts as your remitting agent and is responsible for sending all applications and payments for coverage to the Plan Administrator, as well as notifying you of any changes in payroll deductions for coverage, rate changes, changes in this Plan or in any documents that comprise the Plan, or termination of the Plan or your coverage under the Plan.

## Effective Date for Employees and Dependents

If an employee enrolls for employee/dependent coverage on or before the date of eligibility, coverage shall become effective on the first of the month next following the date of eligibility, as defined herein. If an employee declines coverage and later wishes to enroll in the Plan, enrollment may only be made due to a change in family status or special enrollment, or at the next annual enrollment.

## Who is Eligible to become a Plan Participant?

1. Eligible employees as defined above;
2. The eligible employee's legal spouse, provided such spouse is not legally separated from the employee;
3. The eligible employee's/spouse's children under age 26, including:
   a. Newborn children;
   b. Biological children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the employee;
4. Mentally or physically disabled children incapable of earning a living. The disability must have begun before the child's 26th birthday, and the child must have been covered by the Plan on and continuously since his or her 26th birthday. The employee must submit proof of the child's disability.
5. The eligible employee's adopted grandchild under age 26, living with the employee in a parent-child relationship and primarily supported by the employee. The employee may not enroll a child and grandchild at the same time under the same identification/policy number. The eligible child or grandchild may be covered under a separate identification/policy number.

**Please note: Spouses of married dependent children are not eligible for coverage.**

If an employee and spouse are both eligible for employee coverage, only one will be eligible for coverage with respect to dependents. In addition, the spouse may be deemed to be a dependent and not an employee with respect to the parts of this Plan which provide both employee and dependent coverage.

The Plan Administrator will determine the effective date of coverage for the employee and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call the Plan Administrator.

The Plan Administrator and Contract Administrators reserve the right to verify continued eligibility for all Plan Participants.

## Qualified Medical Child Support Order (QMCSO)

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for medical coverage as stated in the order. A qualified medical child support order is a judgment, decree, or order issued by a court of law which:

- Specifies your name and last known address;
- Specifies the child's name and last known address;
- Provides a reasonable description of the coverage to be provided by the Plan or the manner in which the type of coverage is to be determined;
- States the period of time for which coverage must be provided; and
- Specifies each plan to which it applies.

A Qualified Medical Child Support Order may not require health care coverage that is not already included under the Plan.

## Membership Additions

If you wish to add eligible family members after you have enrolled, there must be a qualifying event and you must:

- Notify the employer;
- File an application within 31 days of the qualifying event; and
- Pay the applicable premium.

**If not enrolled within 31 days from the date of eligibility, applications for enrollment must wait until the annual enrollment period.**

In most cases, the effective date of coverage for added family members will not be the same as your effective date of coverage. The Participating Trust Employer can tell you when enrollment for added family members is allowed under this Plan.

Family members who are eligible because of birth, adoption, marriage, court order, or dependent losing eligibility under other coverage after the Subscriber's effective date of coverage may be added as follows:

**Birth** A newborn is eligible for coverage from the moment of its birth provided the child is enrolled and any required contribution is paid within 31 days after the birth of the baby. If the Participating Trust Employer receives a completed application for change **within 31 days after the date of birth,** coverage is continuous from the moment of birth. The Participating Trust Employer will collect any applicable charges.

**Important Note:** For the first 31 days after birth, the child need not be enrolled in order for claim benefits to be paid. However, for claims incurred after the first 31 days after birth, benefits will not be paid until the child has been properly enrolled, as defined herein.

**Adoption** If the Participating Trust Employer receives an adopted child's application for change **within 31 days after the date the child is adopted or placed for adoption with the employee and/or spouse,** coverage will begin on the date of placement. The Participating Trust Employer will collect any applicable charges. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation of coverage provisions will apply.

**Marriage** When the employee marries, if the Participating Trust Employer receives the spouse's (and any dependent child's, if applicable) completed application for change **within 31 days after the date of marriage,** coverage for listed applicants begins the first of the month next following the date of marriage. The Participating Trust Employer will collect any applicable charges.

**Court Order Changing Custody** When a court order is issued changing custody of a dependent child, if the Participating Trust Employer receives the application for change **within 31 days after the date of the court order**, coverage will begin on the date of the court order. The Participating Trust Employer will collect any applicable charges.

**Dependent Losing Eligibility Under Other Coverage** When a dependent with other coverage loses that coverage, if the Participating Trust Employer receives the application for change **within 31 days of the date the dependent loses coverage**, coverage will begin on the first of the month next following that loss of coverage.

**If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.**

**Annual Enrollment Period** After the initial eligibility date, applications may be submitted during the annual enrollment period established by the Plan. The annual enrollment period is the period designated by the Plan when the employee can elect coverage or modify enrollment. The annual enrollment period is February. Coverage will become effective on March 1st.

**Late Enrollee** An employee or a dependent family member for whom an application for enrollment under this Plan is submitted following the initial enrollment period provided under the terms of the Plan; an employee or dependent family member for whom an application for enrollment is submitted after 31 days following any of the qualifying life events described below, or an employee or dependent family member for whom no application for enrollment is submitted during the annual enrollment period is a late enrollee. A late enrollee may only submit an application during the next annual enrollment period.

**Qualifying Life Events** Subsequent to initial eligibility, applications may also be submitted within 31 days after certain qualifying life events. Ineligibility caused by fraud or misrepresentation does not qualify. Qualifying life events include:

- Marriage;
- Divorce or legal separation;
- Death of a spouse, or dependent child;
- Spouse's (or former spouse covering dependent children) open enrollment period with accompanying significant coverage curtailment, significant cost increase or the addition or elimination of a benefit package option;
- Birth, adoption, or placement for adoption;
- Termination or commencement of the employee's, spouse's or dependent's employment;
- Change in employment of the employee, spouse, or dependent from full-time to part-time status or part-time to full-time status;
- The taking of or return from an unpaid leave of absence by the employee, his/her spouse or dependent;
- Termination of the Plan;
- A court order requiring that coverage be provided for the employee's spouse or the minor child of the employee or the employee's spouse;
- A court order is issued changing custody of a child. The effective date of coverage is the date of the court order;
- You have exhausted your Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits;
- A dependent satisfying or ceasing to satisfy the requirements for dependents;
- The employee's status changes in some other way that permits a benefit change under federal law.

Your employer can tell you when enrollment for added family members is allowed under this Plan. To enroll for coverage or to modify benefits, an application must be completed and submitted to the Plan Administrator or Participating Trust Employer within 31 days after the qualifying life event.

Coverage or modification of benefits will be effective on the first of the month next following the date of the event. (**Exception**: if enrollment is due to birth or adoption, the effective date is the date of the event, provided the participant has properly enrolled, as defined herein.)

**Special Enrollment** If you decline coverage for yourself or your dependents (including your spouse) because you and your dependents are covered under other health care coverage, you may in the future be able to enroll yourself or your dependents, provided you meet each of the applicable conditions outlined below, and you request enrollment within 31 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

**Conditions required for special enrollment:**

1. The employee has declined enrollment in writing stating that coverage under another group health plan or other health insurance coverage was the reason for declining coverage;
2. When the employee declined enrollment in employee and/or dependent coverage, the employee and/or dependent had COBRA continuation coverage under another health plan and COBRA continuation coverage under that other plan has since been exhausted; or
3. If the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
   a. Loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing;
   b. Employer contributions towards the other coverage have been terminated;
   c. Loss of coverage under the Cub Care program (Medicaid);
   d. the member no longer resides in such coverage's permitted service area provided that no other coverage under the plan is available to the Member;
   e. benefits are no longer offered to a class of similarity situated individuals. For example, if a Plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the Plan continues to provide coverage to other employees;
   f. the application of the lifetime maximum benefit through another carrier's coverage;
   g. a dependent loses eligible dependent status. An employee who is already enrolled in a benefit option may enroll in another option under the Plan due to a dependent losing eligible dependent status; or
   h. a dependent who has other coverage loses eligibility under that coverage.

You are not required to elect and exhaust COBRA coverage under another plan to enroll in this Plan during a special enrollment period. If you do elect COBRA coverage under another plan, however, you must exhaust your COBRA coverage under that plan before you can elect to participate in this Plan. Special enrollment rights do not apply if you lose other coverage because you failed to pay your COBRA premiums.

# Other Events Affecting Enrollment

## Family and Medical Leave Act (FMLA) EMPLOYEE RIGHTS AND RESPONSIBILITIES

The Federal Family and Medical Leave Act of 1993 (FMLA) requires certain employers (50 or more employees) to provide up to 12 weeks of unpaid, job-protected leave during a 12-month period (as determined by the Participating Trust Employer) to eligible employees for certain family and medical reasons. Maine law is different, applies to employers of 15 or more persons, and requires up to 10 weeks of unpaid leave. This provision is intended to comply with the law and any pertinent regulations, and they govern its interpretation. See your employer to find out details about how this continuation applies to you.

**Basic Leave Entitlement**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

**Military Family Leave Entitlements**
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

**Benefits and Protections**
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

**Definition of Serious Health Condition**
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**Use of Leave**
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of Paid Leave for Unpaid Leave**
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

**Employee Responsibilities**
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need

for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer Responsibilities**
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

**Unlawful Acts by Employers**
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

**Enforcement**
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

## Absence From Work Due to an Approved Leave of Absence (other than under FMLA)

If an employee is granted a leave of absence (other than the FMLA), participation in the Plan is continued, not to exceed 14 weeks and subject to payment of the necessary contributions. If the employee does not return to work at or before the end of the 14 weeks or does not continue the necessary contributions, eligibility in the Plan is terminated and COBRA continuation coverage will be offered.

## Children's Health Insurance Program Reauthorization Act (CHIPRA)

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans and group health insurance issuers must offer new special enrollment opportunities. Effective April 1, 2009, plans and issuers must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- losing eligibility for coverage under a State Medicaid or CHIP program, or
- becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

## Return to Work

An employee who returns to active, full-time employment with the same Participating Trust Employer within 30 days following a leave of absence, temporary layoff or termination of employment shall not have a break in coverage provided that they pay contributions to the Plan that were not paid. Employees who return to active full-time employment with the same Participating Trust Employer within 6 months (but not within 30 days as outlined above) shall not be subject to the waiting period applicable to new employees.

## Return to Work Following Military Call Up to Active Duty

If an employee returns to active full-time employment following a military call up to active duty, the waiting period for new employees will not apply. All benefits defined in this Plan Document will be restored to their status as of the employee's last day worked provided the employee applies for re-employment with a Participating Trust Employer within the timeframe defined under the Uniformed Services Employment and Reemployment Rights Act, as amended (USERRA). Coverage under this Plan will be effective on the date the reservist returns to full-time active employment.

### Plan Re-Entry

Any Plan Participant who was formerly covered under this Plan, either as an employee or as a dependent, and who again becomes covered hereunder, either as an employee or as a dependent, shall not have his full maximum benefit restored solely by reason of the fact that the individual has again become covered under the Plan. The maximum benefit with respect to such individual shall be reduced by any benefits previously paid under the provisions of this Plan.

### Transfer of Coverage

This provision applies if this Plan replaces another group health plan. However, it only applies to those individuals covered by the other group health Plan coverage on the day before this Plan goes into effect for a new Employer. Credit will be given under this Plan for service requirements and deductibles met in part or in full under the provisions of the group health Plan coverage being replaced.

### Right to Reinstatement

The Plan Participant may be eligible to reinstate coverage within 90 days following termination of coverage if contributions were not made due to the Plan Participant suffering from cognitive impairment or functional incapacity at the time of termination. When reinstatement is requested, the Plan may require a physician examination at the Plan Participant's expense or request medical records to confirm the condition existed at the time of termination of coverage. If the Plan accepts the proof, eligibility into the Plan is reinstated without a lapse in coverage, subject to the same terms, conditions, exclusions and limitations. In addition, the Plan Participant is also responsible for paying contributions to the Plan that were not paid. The Plan Participant will receive a notice from the Plan if reinstatement is denied. The Plan Participant has the right to request a hearing before the Superintendent of Insurance within 30 days after the notice is received.

### Increases/Decreases in Coverage

Any increase or decrease in the amount of coverage of a Plan Participant will become effective on the date of such change.

## Termination of Coverage

### Termination Date for Employees and Dependents

Employee coverage will terminate on the earliest to occur of the following dates:

- The date on which the Plan is terminated;
- The last day of the period for which contribution has been made, if the employee or the Participating Trust Employer fails to make any contribution which may be required;
- The last day of the calendar month in which the employee ceases to be included in a class of eligible employees;
- The last day of the calendar month in which employment with a Participating Trust Employer is terminated.

Coverage with respect to a dependent will terminate upon the earliest to occur of the following dates:

- The date on which the employee's coverage terminates;
- The last day of the calendar month in which the employee's dependent coverage under the Plan terminates;

- The last day of the calendar month in which the dependent ceases to be included in the classes of persons eligible for dependent coverage, including marriage;
- The last day of the calendar month in which contribution has been made, if the employee or the Participating Trust Employer fails to make any contribution which may be required;
- The last day of the calendar month in which the covered dependent does not satisfy the eligibility requirements, as defined herein.

# Continuation Coverage (COBRA)

**This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

**What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

**When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.**

**How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This

extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

**Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Administrator contact information**
The Maine Automobile Dealers Association, Inc.
180 Civic Center Drive
PO Box 2667
Augusta, ME 04338-2667
(207) 623-3882

## Continuation Coverage (USERRA)

A loss of coverage resulting from an absence from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services will entitle an Employee and the Employee's covered spouse and dependents to continue coverage under the Plan beginning as of the first day of the Employee's absence for such duty. This continuation coverage is separate from COBRA continuation coverage and applies to employees of all Participating Trust Employers. The maximum period of such coverage is the lesser of:

**(1) The 24-month period beginning on the date on which the employee's absence for the purpose of performing service begins; or,**

**(2) The period beginning on the date on which the employee's absence for the purpose of performing service begins, and ending on the date on which he or she fails to return from service or apply for a position of employment as provided under sections USERRA.**

The Participating Trust Employer shall furnish the Employee a notice of the right to elect continuation coverage under USERRA. The cost of such coverage shall be borne entirely by the Employee and the Employee's

covered spouse and dependents and shall not be more than 102% of the applicable premium for the coverage elected.

# Section Three
# Utilization Management

All services you receive are subject to the provisions in this section. Failure to comply with any or all of the requirements listed below will result in a penalty, or in denial or reduction of your benefits. If you have any questions, please call the number on the back of your ID card.

If you have a health concern, please contact your physician.

The Utilization Management Program encourages quality, cost-effective health care by helping a Plan Participant make informed decisions about health care alternatives. Designed to ensure health care services are medically necessary and appropriately used, the program's registered nurses and physician evaluators work with patients, their doctors, the treatment facility, and the administrator of the benefit plan to guide them to appropriate benefit utilization.

This review is to determine financial reimbursement if the requested benefit is a covered service. The decision for treatment is solely between the patient and physician, regardless of the decision made regarding reimbursement.

None of the Contract Administrator's employees or the providers or professionals under contract to make medical management decisions are paid or provided incentives to deny or withhold benefits for services that are medically necessary and are otherwise covered under the Plan. In addition, the Contract Administrator requires members of the clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying benefits for services that are medically necessary and are otherwise covered under the Plan.

The Contract Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in the Contract Administrator's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Contract Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Contract Administrator may also exempt your Claim from medical review if certain conditions apply.

Just because the Contract Administrator exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that the Contract Administrator will do so in the future, or will do so in the future for any other Provider, Claim or Plan Participant. The Contract Administrator may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory or contacting customer service number on the back of your ID card.

## Contract Administrator's Medical Policy

The purpose of medical policy is to assist in the interpretation of medical necessity. However, this Plan Document takes precedence over medical policy. Medical technology is constantly changing and the Contract Administrator reserves the right to review and update medical policy periodically.

## Prior Authorization

Some services require prior authorization before benefits will be provided. If you have any questions regarding Utilization Management or to determine which services require prior authorization, please call the number on

the back of your ID card. Prior Authorization does NOT guarantee coverage for or payment of, the service or procedure reviewed. Contact your physician or the Contract Administrator to be sure that prior authorization has been obtained.

## Plan Participants' Rights and Responsibilities

You have the right to:

- Request in writing a copy of the clinical review criteria used in arriving at any denial or reduction of benefits;
- Appeal any adverse determinations based on medical necessity;
- Refuse treatment for any condition, illness, or disease without jeopardizing future treatment.

## How to Access Primary and Specialty Care Services

Your health plan covers certain primary and specialty care services. To access primary care services, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan covers care provided by any network specialty care provider you choose. Referrals are never needed to visit any network specialty care provider.

To make an appointment call your physician's office:

- Tell them you are an Anthem PPO member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, take your Member ID card.

## When you need care after normal office hours

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an emergency, call 911 or go to the nearest emergency room.

## Procedure for Appeal of Medical Necessity

If you disagree with an adverse determination of medical necessity, you have the right to appeal as outlined in the Benefit Determinations, Payments and Appeals section of this Plan Document.

## Inpatient Admission Review

**Pre-Admission Review** All inpatient admissions, with the exception of emergency and maternity admissions, require pre-admission review.

You, your physician or the provider must call the telephone number on your ID card for review before you are admitted. It is your responsibility to make sure the call has been placed. If you do not receive pre-admission review before you are admitted for non-emergency services, benefits will be reduced by up to $300 for the admission. This penalty amount does not count toward your deductible or coinsurance limit.

The Contract Administrator will notify you and your physician of the results of the pre-admission review within 2 working days after receipt of all necessary information regarding the proposed admission. For special rules that apply to maternity admissions, see the Continued Inpatient Stay Review provision in this section.

**Post-Admission Review** All inpatient admissions for emergency and maternity services are subject to post-admission review. For post-admission review of an emergency admission, you, a family member, your physician, or the provider should call within 48 hours after you are admitted. For maternity post-admission review, you, a family member, your physician, or the provider should call if the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. The Contract Administrator will notify you and your physician of the results of the post-admission review within 2 working days after receiving all necessary information.

If you are admitted to a non-network hospital or other non-network health care facility, benefits are provided at the higher benefit level only until the Contract Administrator determines that your condition reasonably permits your transfer to a network hospital or other network health care facility. If you choose not to be moved once your condition permits, benefits will be provided at the lower benefit level from that point forward.

For emergency and maternity admissions, call the telephone number on your ID card. You can call 24 hours a day, seven days a week. During non-business hours, you may be asked to leave your information on a confidential voice messaging system.

For special rules that apply to maternity admissions, see the Continued Inpatient Stay Review provision below.

**Continued Inpatient Stay Review** During your stay in the hospital, the Contract Administrator's registered nurses and physician advisors evaluate your progress to determine the appropriateness of the services being rendered, appropriateness of the setting, discharge planning needs and coordination of alternatives to inpatient care. If it is determined that inpatient benefits are no longer approved, your attending physician will be notified immediately by telephone and you will be notified by letter that benefits will not be available beyond a certain date specified in the letter, if you are liable for the entire cost of continued care.

If you elect to continue your hospital stay after you have been notified by letter that no further inpatient days are approved, benefits for inpatient days beyond the date specified in the notification letter will be denied. You are entitled to appeal this determination as outlined in this Plan Document.

**Note:**

**Maternity Admissions** - This Plan generally may not, under federal law, restrict benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

The inpatient length of stay for a maternity admission will be determined by the attending physician in consultation with the patient as outlined in the Covered Services section. In any case, this Plan may not, under federal law, require authorization from the Contract Administrator for prescribing a length of stay that does not exceed 48 hours (or 96 hours as applicable).

**Admissions for the Treatment of Breast Cancer** - The inpatient length of stay for a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer, will be determined by the attending physician in consultation with the patient.

**Notice Regarding Women's Health and Cancer Rights Act**

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, you may call the telephone number on your ID card.

**Discharge Planning** You may be ready to be discharged from a provider even though you still need medical care. In that case, the Contract Administrator will work with you and your physician to make arrangements for treatment even after you are released from the provider.

## Inpatient Mental Health/Substance Abuse Review

Authorization for inpatient mental health and substance abuse services must be obtained through the Contract Administrator's mental health care manager. You, your doctor, or the provider must call for authorization. Unless you have an emergency medical condition, you must call the telephone number on your ID card for prior authorization of all inpatient mental health and substance abuse services before you receive the services. It is your responsibility to make sure you receive prior authorization for all non-emergency inpatient mental health and substance abuse services. If you do not call for prior authorization for inpatient mental health and substance abuse services before you receive the services, your benefits may be reduced by up to $300. Benefits may be denied if it is determined that services received were not medically necessary.

## Individual Care Management

The Contract Administrator has a care management program that is tailored to the individual. The care managers work collaboratively with Plan Participants and their families and providers to coordinate the Plan Participant's health care benefits.

In certain extraordinary circumstances involving intensive care management, the Plan may provide benefits for alternate care that is not listed as a covered service. The Plan may also extend covered services beyond the contractual benefit limits of this Plan. The decision is made on a case-by-case basis. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Plan Participant. The Plan reserves the right, at any time, to alter or cease providing extended benefits or approving alternate care. In such case, the Contract Administrator will notify you or your representative in writing.

## Pilot or Test Programs

The Plan may institute pilot or test programs regarding case management, disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in the Plan Document. The Plan reserves the right to discontinue a pilot or test program.

## Network Providers and Professionals

The Plan uses a network of Providers and Professionals to provide covered services. A list of Network Providers and Professionals is available online at **anthem.com** or is available, without charge, upon request made to the Plan Administrator or by contacting a customer service representative at the toll free number listed on the back of your subscriber card. The use of Network Providers and Professionals will maximize Benefits available under the Plan.

## Continuity of Care

If you are undergoing a course of treatment and the treating provider or professional withdraws from this network, you will be notified of the termination. You may be allowed to continue receiving care from the withdrawing provider or professional for a period of 60 days from the date of notice of termination or through the end of postpartum care if you are in the second trimester of a pregnancy, if the provider or professional:

- Agrees to accept the same rates of reimbursement that were in effect prior to the date of termination;
- Agrees to adhere to applicable quality assurance standards and to provide the Contract Administrator with the necessary medical information related to the care provided you; and
- Agrees to adhere to Plan policies and procedures.

## Network Provider or Professional Unavailable

If you are unable to obtain services from a network provider or professional, you or your doctor should call the telephone number on your ID card. Care managers will work with you or your doctor to locate a network provider or professional. If it is determined by the care manager that no network provider or professional is available, the Contract Administrator will authorize covered services from a non-network provider or professional. Benefits will be reimbursed at the higher network level.

# Section Four
# Covered Services

This section, along with the Exclusions section, explains health care services for which the Plan will and will not provide benefits. All benefits and covered services are subject to the deductibles, coinsurance, copayments, maximums, exclusions, limitations, terms, provisions and conditions of this Plan, including any attachments and amendments or riders. Benefits for covered services are based on the Maximum Allowed Amount under the Plan. To receive maximum benefits for covered services, you must follow the terms of the Plan Document including use of in-network providers and professionals and obtaining any required prior authorization.

The Plan's payment for covered services will be reduced by any applicable copayment, deductible or coinsurance. Please check your Benefit Summary for deductibles, copayments, coinsurance, maximums, and limitations that apply. Please see the Utilization Management section for conditions that apply to all inpatient admissions and outpatient mental health and substance abuse services.

Benefits for covered services may be payable subject to an approved treatment plan. Only medically necessary care is covered. Although the Plan does not provide benefits for covered services that do not meet the Plan's definition of medical necessity, you and your physician must decide what care is appropriate. The fact that a physician may prescribe, order, recommend or approve a service, treatment or supply does not make it medically necessary or a covered service and does not guarantee payment. If you choose to receive care that is not a covered service or does not meet the definition of medical necessity, the Plan will not provide benefits for it. Decisions about prior authorization, medical necessity, experimental services and new technology are based on medical policy developed by the Contract Administrator. The Contract Administrator may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Unless specifically stated otherwise, all benefits, limitations and exclusions under this Plan apply separately to each Plan Participant.

A Plan Participant's right to benefits for covered services provided under this Plan is subject to certain policies or guidelines and limitations, including, but not limited to, medical policy, continued inpatient stay review, pre-admission review, post-admission review, and prior authorization. A description of each of these guidelines explaining its purpose, requirements and effects on benefits is provided in the Utilization Management section. Failure to follow the Utilization Management guidelines for obtaining covered services will result in reduction or denial of benefits.

**Allergy Testing and Injections** The Plan provides benefits for allergy testing and injections.

**Ambulance Service** The Plan provides benefits for local transportation by a licensed vehicle (including an air or water ambulance if medically necessary) that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a hospital when other transportation would endanger your health.

If no hospital in your local area is equipped to provide the care you need, the Plan will provide benefits for ambulance transportation to the nearest facility outside your area that can provide the necessary care. If you are transported to a hospital that is not the nearest hospital that can meet your needs, benefits will be based on transport to the nearest hospital that can meet your needs.

**Ambulatory Surgery Centers** The Plan provides benefits for certain covered services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility's licensure.

**Anesthesia Services** The Plan provides benefits for anesthesia only if administered while a covered service is being provided, except as outlined in the Dental Procedures provision. The Plan does not provide benefits for local or topical anesthesia unless it is part of a regional nerve block.

**Autism spectrum disorders** The Plan provides benefits for the treatment of autism spectrum disorders **(for members who are 10 years of age or under)** when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

**Blood Transfusions** The Plan provides benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

**Chemotherapy Services** The Plan provides benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by infusion, perfusion, intracavity or parenteral means such as intravenous, intramuscular, or intrathecal. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by the Contract Administrator for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the Contract Administrator for medically accepted indications or as required by law.

**Children's early intervention** Plan provides benefits for services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411, et seq. A referral from the child's primary care provider is required and coverage.

**Chiropractic Care** The Plan provides benefits for chiropractic care. See the Manipulative Therapy provision for additional information and your Benefit Summary for limits that apply.

## Clinical Trials

The Plan provides benefits for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   i. The Department of Veterans Affairs.
   ii. The Department of Defense.
   iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

i. The Investigational item, device, or service, itself; or
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

**Colorectal Tests** The Plan provides benefits for medically necessary colorectal tests as described in the Preventive and Well-Care Services provision in this section.

**Contraceptives** The Plan Provides benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis.

**Dental Procedures** The Plan provides benefits for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the member is classified as vulnerable. Examples of vulnerable members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial or dental trauma
- Individuals who are extremely uncooperative, fearful or anxious

**Dental Services** The Plan provides benefits only for the following:

- Setting a jaw fracture
- Removing a tumor (but not a root cyst)
- Removing impacted or unerupted teeth in a non-hospital or non-rural health center setting
- Treating accidental bodily injury to natural teeth when injury incurred as a result of an accident sustained while covered under the Plan or the prior Plan
- Repairing or replacing dental prostheses damaged by an accidental bodily injury that occurs while you are covered under this Plan

**Diabetic Services** The Plan provides benefits for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by the Contract Administrator.

**Diagnostic Services** The Plan provides benefits for diagnostic services, including diagnostic laboratory tests and x-rays, when they are ordered by a professional to diagnose specific signs or symptoms of an illness or injury or when the services are part of well-baby or well-adult care stated as covered under this contract. You must receive prior authorization from us for the diagnostic services which include but are not limited to: CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans. Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.

**Durable Medical Equipment and Prostheses** If more than one treatment, prosthetic device, or piece of durable medical equipment may be provided for your disease or injury, benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs. These terms apply to the following services:

**Durable Medical Equipment** The Plan provides benefits for the rental or purchase (when economically justified) of durable medical equipment. Whether you rent or buy the equipment, benefits are provided for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, the Plan will make monthly payments only until the covered share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first, unless purchasing the equipment is not an option.

Benefits for replacement or repair of purchased durable medical equipment are subject to Plan approval. The Plan does not provide benefits for the repair or replacement of rented equipment.

Supplies are covered if they are necessary for the proper functioning of the durable medical equipment.

**Prostheses** The Plan provides benefits for prostheses. Prostheses include artificial limbs, eyes and prosthetic appliances. Benefits are provided for the prosthetic appliance which most appropriately meets your medical needs.

The Plan does provide benefits for prosthetics that are micro-processor controlled, but only once in any 60 month period, and will only consider, as eligible charges, up to the then current calendar year Centers for Medicare & Medicaid Services (CMS) Maine specific Durable Medical Equipment, Prosthetics/Orthotics & Supplies (DMEPOS) fee schedule. You will be responsible for any difference between the DMEPOS fee schedule and Provider's or Professional's charge, in addition to any applicable copayment, deductible or coinsurance.

The fee schedule is currently available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule-Items/DME14-B-List.html?DLPage=6&DLSort=2&DLSortDir=ascending
Please refer to the Exclusions section for additional information.

**Emergency Room Care** The Plan provides benefits for emergency room treatment received for medical emergencies. You or a designated person should contact your physician within 48 hours from the time you receive care.

If you are admitted to the hospital from the emergency room, you or a designated person should contact your physician within 48 hours from the time you are admitted. If you do not contact your physician, you or someone you designate should call the telephone number listed on your ID card within 48 hours of admission.

**Eye Examinations** The Plan provides benefits for routine vision exams, limited to one exam each calendar year.

**Family Planning** The Plan provides benefits for family planning. See the Contraceptives provision within this section for details.

**Foot Care** The Plan provides benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

**Freestanding Imaging Centers** The Plan provides benefits for diagnostic services performed by freestanding imaging centers. All services must be ordered by a professional.

**Hearing Care** The Plan provides benefits for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, who is 18 years of age or under in accordance with the following requirements:

- The hearing loss must be documented by a physician or licensed audiologist;
- The hearing aid must be purchased from a licensed audiologist, or licensed hearing aid dealer;
- The Plan limits coverage to one hearing aid for each hearing-impaired ear every 36 months.

Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

**Home Health Care Services** The Plan provides benefits for home health care services when services are performed and billed by a home health care agency. A home health care agency must submit a written plan of care, and then provide the services as approved by the Contract Administrator.

The Plan provides benefits for the following home health care services:

- Physician home and office visits;
- Registered nurse (RN) or licensed practical nurse (LPN) nursing visits;
- Services of home health aides when supervised by an RN;
- Paramedical services, including physical therapy, speech therapy, occupational therapy, inhalation therapy, and nutritional guidance;
- Supportive services, including prescription drugs, medical and surgical supplies, and oxygen.

**Home Infusion Therapy** The Plan provides benefits for home infusion therapy when provided and billed by a home infusion therapy provider. Supplies and equipment needed to appropriately administer home infusion therapy are covered.

**Hospice Care Services** The Plan provides benefits for hospice care services furnished in your home by a home health agency to a Plan Participant who is terminally ill and the Plan Participant's family. A Plan Participant who is terminally ill means a person who has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course.

The Plan provides benefits for hospice care services by a home health agency up to 24 hours during each day of care. Hospice care services are provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Prior approval is required when care exceeds eight hours a day.

In this case, the agency must submit a plan of care to receive approval. The agency must then submit a plan of care every 14 days to maintain approval. To be eligible for hospice care services, the patient need not be homebound or require skilled nursing services. Coverage for hospice care services is provided in either a home or inpatient setting.

Hospice care services include, but are not limited to: physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and durable medical equipment, occupational, physical or speech therapies, home health care services, bereavement services and volunteer services.

**Hospice Respite Care** The Plan provides benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide hospice care.

Before the patient receives respite care at home, a home health agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an inpatient hospice.

**Inpatient Hospice Services** The Plan provides benefits for inpatient hospice care at an acute care hospital or skilled nursing facility. The same services are covered for inpatient hospice care as are covered under inpatient hospital services.

**Inborn Errors of Metabolism** The Plan provides benefits for metabolic formula and special modified low-protein food products. The formula or food must be specifically manufactured for patients with diseases caused by inborn errors of metabolism. This benefit is limited to those Plan Participants with diseases caused by inborn errors of metabolism.

**Independent Laboratories** The Plan provides benefits for diagnostic services performed by independent laboratories. All services must be ordered by a professional.

**Individual with Disabilities Education Act** The Plan provides benefits, to the extent as defined herein, provided to children in addition to or in lieu of the services which may be available, provided and/or used under a federal or state mandated program such as the Individual with Disabilities Education Act, Public Law 105-17.

**Infant formula** The Plan provides benefits for amino acid-based elemental infant formula for children 2 years of age and under in accordance with this section.

**1. Determination of medical necessity.** Coverage for amino acid-based elemental infant formula is provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A, subsection 10-A, that the amino acid-

based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing medical necessity at least annually.

**2. Method of delivery.** Coverage for amino acid-based elemental infant formula is provided without regard to the method of delivery of the formula.

**3. Required diagnosis.** Coverage for amino acid-based elemental infant formula is provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

A. Symptomatic allergic colitis or proctitis;

B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis;

C. A history of anaphylaxis; [2007, c. 695, Pt. C, §15 (RAL).]

D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;

E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;

F. Cystic fibrosis; or

G. Malabsorption of cow milk-based or soy milk-based infant formula.

**Inhalation Therapy** The Plan provides benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

**Inpatient Hospital Services** The Plan provides benefits for the following inpatient hospital services:

- Room and board, including general nursing care, special duty nursing, and special diets in a semiprivate room or a private room when medically necessary;
- Use of intensive care or coronary care unit;
- Diagnostic services;
- Medical, surgical, and central supplies;
- Treatment services;
- Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, and inpatient occupational therapy, physical therapy, inhalation therapy, and radiotherapy services;
- Phase I cardiac rehabilitation;
- Medication used when you are an inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by the Plan for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the Plan for medically accepted indications or as required by law;
- Blood and blood derivatives;
- Prostheses or orthotic devices;
- Newborn care, including routine well-baby care.

Benefits for an inpatient stay in a hospital will end with the earliest of the following events:

- You are discharged as an inpatient;
- You reach any of the limits or maximums shown in your Benefit Summary;
- Your physician, hospital personnel, or the Contract Administrator notify you that inpatient care no longer meets guidelines for continued hospital admission.

**Manipulative Therapy** The Plan provides benefits for treating acute musculo-skeletal disorders. No benefits are provided for ancillary treatment such as massage therapy, heat and electrostimulation unless in

conjunction with an active course of treatment. Benefits are not provided for maintenance therapy for chronic conditions.

**Medical Care** The Plan provides benefits for medical care and services including office visits and consultations, hospital and skilled nursing facility visits, and pediatric services.

**Medical Supplies** The Plan provides benefits for medical supplies furnished by a provider in the course of delivering medically necessary services. This benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a physician.

**Mental Health and Substance Abuse Services - Professional** The Plan provides benefits for only the following mental health and substance abuse services when they are for the active treatment of mental health and substance abuse disorders. These services must be part of an established plan of treatment and must be performed and independently billed by a professional acting within the scope of his or her license:

- Individual and group counseling;
- Family counseling;
- Psychological testing;
- Diagnostic and evaluation services;
- Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring an immediate and acute need for treatment;
- Intervention and assessment.

You will receive maximum benefits for mental health and/or substance abuse services when you receive care from network providers and professionals.

**Mental Health and Substance Abuse Services - Provider** The Plan provides benefits for inpatient, outpatient, and day treatment services for mental health and substance abuse when you receive them from a provider. You will receive maximum benefits for mental health services when you receive care from network providers and professionals.

If you receive provider services from a community mental health center or substance abuse treatment facility, services must be:

- Supervised by a licensed physician, licensed clinical psychologist, licensed clinical social worker, or other providers as required by law; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

The Plan provides benefits for only the following mental health and/or substance abuse treatment services:

- Room and board, including general nursing;
- Prescription drugs, biologicals, and solutions administered to inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.

The Utilization Management section contains additional information about seeking mental health and substance abuse services. Please refer to your Benefit Summary for additional information regarding mental health and substance abuse benefits.

**Morbid Obesity** The Plan provides limited benefits for treatment of morbid obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. Prior authorization is required. Benefits are not provided for weight loss medications.

**Nutritional Counseling**The Plan provides Benefits for nutritional counseling when required for a diagnosed medical condition. This benefit is limited to three visits per calendar year.

**Obstetrical Services and Newborn Care** The Plan provides benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. Coverage will be provided for circumcisions when performed on a newborn.

**Office Visits** The Plan provides benefits for office visits. Office visits are subject to a copayment. Please refer to your Benefit Summary. Office visits to Network Providers are not subject to the Deductible or Coinsurance. Office visits to Non-Network Providers are not subject to the Deductible and will be paid at the non-network level of Benefits. Office visits include visits to a Walk-In Center. Office visits include visits to a retail health clinic. Services at a retail health clinic are limited to basic health care services to Members on a 'walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by physician's assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

**Online Visits** When available in your area, your coverage will include online visit services. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Covered Services include a medical consultation using the internet via a webcam, chat or voice. Non Covered Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician to Physician consultation

Please refer to the "Telemedicine" provision as you may have additional or different services available.

**Orally Administered Cancer Therapy**
The Plan provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.

**Organ and Tissue Transplants** The Plan provides benefits for organ and tissue transplant procedures listed below. You must receive prior approval from the Contract Administrator before you are admitted for any transplant procedure. Your physician will work with the Contract Administrator's registered nurses and physician advisors to evaluate your condition and determine the medical appropriateness of a transplant procedure. Failure to receive approval prior to admission may result in a denial or reduction of benefits.

***Transplants include:***

Adrenal gland, allogeneic bone marrow, autologous bone marrow, blood vessel, bone, cartilage, cornea, heart, heart/lung, heart valve, islet tissue, kidney, liver, lung, muscle, pancreas, parathyroid, skin, tendon.

No other organ or tissue transplant is covered. The Plan will not pay any benefits for any services related to a transplant that is not covered.

The Plan provides benefits as follows:

- If both the donor and the recipient are covered under the Plan, the Plan will provide benefits to cover both patients for organ and tissue transplants;
- If the recipient is covered under the Plan but the donor is not, then the Plan will provide benefits for both the recipient and donor as long as similar benefits are not available to the donor from other sources;
- If the recipient is not covered under the Plan but the donor is, the Plan will not provide benefits to either the donor or the recipient.
- **Human Leukocyte Antigen Testing** The Plan provides coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:
- The member covered under the plan meets the criteria for testing established by the National Marrow Donor Program, or its successor organization;
- The testing is performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;
- At the time of the testing, the member covered under the plan completes and signs an informed consent form authorizing the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; and
- The Plan does not impose any cost-sharing requirements (deductible, coinsurance or copayment) but does limit benefits to one test per covered member per lifetime.

**Orthotic Devices** The Plan provides benefits for certain orthotic devices, such as orthopedic braces, back or surgical corsets, splints, prescribed corrective appliances inside shoe and prescribed gradient compression stockings. Benefits for wigs will be provided when necessary due to chemotherapy or other cancer related treatment, limited to a lifetime maximum benefit of $500. Benefits are not provided for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

**Outpatient Services** The Plan provides benefits for the following hospital outpatient and rural health center services:

- Emergency room services/emergency care;
- Removal of sutures;
- Application or removal of a cast;
- Diagnostic services;
- Surgical services;
- Removal of impacted or unerupted teeth;
- Endoscopic procedures;
- Blood administration;

- Radiation therapy;
- Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with the Contract Administrator to see if you are eligible for benefits;
- Outpatient educational programs such as diabetes education. Please check with the Contract Administrator to see of you are eligible for benefits.

**Parenteral and Enteral Therapy** The Plan provides benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

**Physical and Occupational Therapy** The Plan provides benefits for short-term physical and occupational therapy on an outpatient basis for conditions that are subject to significant improvement. Benefits are subject to a combined calendar year limit as described on your Benefit Summary. Services are covered only when provided by a licensed professional acting within the scope of his/her license.

No benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

**Prescription Drugs** The Plan provides benefits under your prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a hospital. The Covered Drug Copayment or Coinsurance may vary based on whether the Prescription Drug has been classified by the Contract Administrator as a Tier 1, Tier 2, Tier 3, or Tier 4 Drug.

Anthem BCBS/WellPoint, Inc. has established the WellPoint National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignment of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

## Continuity of Prescription Drugs

We reserve the right to request a review of your previous insurance carrier's prescription drug prior authorization with your prescribing provider. If your provider participates in the review and requests that the prior authorization be continued, we will honor the previous insurance carrier's prior authorization for a period not to exceed 6 months beginning with your effective date of coverage with us.

- The cost share requirements of this plan will apply. We do not provide benefits for conditions or services not otherwise covered under this certificate.

- All other terms, conditions, exclusions and limitations to your Maine Automobile Dealers Association Insurance Trust Group Medical Plan (030484) apply to this amendment.

The determination of tiers is made by the Contract Administrator based upon clinical decisions provided by their National P & T Committee, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives, and where appropriate, certain clinical economic factors.

You may review a copy of the current tier listing online at: www.anthem.com or you may request a copy of the tier listing by calling a customer service representative at the number of the back of your ID card. The tier

listing is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage. Refer to the prescription drug Benefit sections in this Certificate for information on coverage, limitations and exclusions.

Certain Prescription Drugs are not covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem on appeal to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing for the appeal, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative. For additional information please consult our website at www.anthem .com or contact Customer Service at the number on the back of your ID card.

The Contract Administrator retains the right at its discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another Tier.

- Tier 1 drugs have the lowest copayment. This tier will contain low cost and preferred medications that may be generic, single source brand drugs, or multi-source brand drugs.
- Tier 2 drugs will have a higher copayment than those in tier 1. This tier will contain preferred medications that may be generic, single source, or multi-source brand drugs.
- Tier 3 drugs will have a higher copayment than those in tier 2. This tier will contain non-preferred and high cost medications. This will include medications considered generic, single source brands, or multi-source brands.
- Tier 4 drugs will have the highest copayment. This tier typically applies to specialty drugs.

From time to time we may initiate various programs to encourage covered persons to utilize more cost effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, OTC, or preferred products. Such programs may involve reducing or waiving copayments or coinsurance for certain drugs or preferred products for a limited period of time.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require prior authorization of benefits. Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system and the pharmacist is instructed to contact the pharmacy benefits manager (PBM). The PBM is a pharmacy benefit management company with which the Contract Administrator contracts to manage your pharmacy benefits. Please see the "Benefit Determinations, Payments and Appeals" section for additional information.

The PBM uses pre-approved criteria, developed by the Contract Administrator's national Pharmacy and Therapeutics Committee and reviewed and adopted by the Contract Administrator. The PBM communicates the results of the decision to the pharmacist. The PBM may contact your prescribing physician if additional information is required to determine whether prior authorization should be granted. If prior authorization is denied, you have the right to appeal through the appeals process outlined in the "Benefit Determinations, Payments and Appeals" section of this certificate.

Please note one exception to the prior authorization requirement. When the prior authorization is initiated but cannot be completed, the Contract Administrator may authorize coverage for a sufficient amount of the Prescription Drug which will provide the additional time for the Contract Administrator to make the prior authorization decision.

For a list of current drugs requiring prior authorization, please contact a customer service representative at the number on the back of your ID card or consult the website at **www.anthemprescription.com.** The tier listing

is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage.

**Prescription Drugs From A Retail Pharmacy** When your prescription is filled at a retail Pharmacy, you pay the amount shown on your Benefit Summary. Certain participating retail pharmacies can fill your prescription at the same Copayments that apply to the mail order Pharmacy. Please ask your Pharmacy if they participate in this special arrangement or call the Contract Administrator's Customer Service Department at the number on your ID card for a list of participating pharmacies.

**Prescription Drugs By Mail** Your Plan allows you to obtain Prescription Drugs by mail. To obtain Benefits for Prescription Drugs by mail, complete a mail order Pharmacy form, available through the Contract Administrator's Customer Services Department, and mail it with your prescription. You must pay the applicable Copayment amount indicated on your Benefit Summary.

**Specialty Pharmacy Network** You or your physician can order Specialty Drugs directly from any Network, Specialty Network or Non-Network Pharmacy. If you or your physician orders your Specialty Drugs from a Specialty Participating Pharmacy you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate any shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

Specialty pharmacies may fill retail and mail service Specialty Drug prescription orders, subject to a 30-90 day supply. The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or a mail order vendor. You may obtain a list of specialty drugs available through the Specialty Pharmacy Network by contacting the Customer Service number on the back of your ID card, or by visiting our website www.anthem.com.

A list of participating Specialty Pharmacies is available by contacting the Customer Service number on your ID card, or by visiting our website www.anthem.com.

**Changes In Your Prescription** Your pharmacist may check your prescription to determine if there may be harmful interactions between the prescription you are filling and any other prescription you may be taking. The pharmacist may contact your Physician to discuss possible changes to your prescription.

**Refills on Prescriptions** Your Physician will indicate the number of refills for your prescription. The Plan will cover the refill for your prescription when you have taken 85% of the medication, based on the dosage schedule prescribed by the Physician. The Plan will not provide Benefits for refills that are filled sooner.

**Maintenance Prescription Supplies** Benefits are provided for up to a 90-day supply if prescribed by your Physician as medically appropriate. Please refer to your Benefit Summary for Copayment amounts that apply to you.

**Step-Therapy Protocol Screening** For many conditions, the FDA has approved more than one medication for use. These include first-line medications customarily utilized to treat the condition and second-line medications. Second-line medications may be prescribed for patients who have utilized a first-line medication for their condition which has not been completely effective or for patients that may experience side effects with the first-line medication. We will provide Benefits for certain second-line medications only after you have previously attempted to use an appropriate first-line medication and it was not completely effective or it would result in complications or side-effects.

**Therapeutic Substitution of Drugs** Your Pharmacy benefit includes a therapeutic drug substitution program approved by the Contract Administrator and managed by the PBM. This voluntary program is designed to

inform Members and Physicians about tiering alternatives. The PBM may contact the Member, the Member's representative, or the prescribing Physician to make the Member aware of tiering substitution options. Only the Member and the Member's Physician can determine whether the therapeutic substitution is appropriate.

**Half-Tablet Program** The Half-Tablet Program will allow Members to pay a reduced copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member's decision to participate should follow consultation with and the concurrence of his/her Physician. To obtain a list of the products available on this program call the Customer Service number on the back of your ID card.

**Vacation Supplies** If you are going out of the area for an extended period of time and your supply of medications is not sufficient for this period, you may contact your Pharmacy or the prescribing Physician prior to leaving the area to receive an early refill or an extended-day supply of medications while you are away from home. Controlled substances are excluded from this program.

**Preventive Care** The Plan provides benefits for Preventive Care. Services include Outpatient services and Office Services.

Note: Screenings and other services are generally covered as Preventive Care for adults and children with no current signs or symptoms of a medical condition. Members who have current signs or symptoms of a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit and subject to the coinsurance and/or deductible applicable to your plan.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the Member when provided by a Network Provider, if applicable to your plan. That means the Plan pays 100% of the Maximum Allowed Amount. There will be no balance billing when a Network Provider is used. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   Breast cancer;
   Cervical cancer;
   Colorectal cancer;
   High Blood Pressure;
   Type 2 Diabetes Mellitus;
   Cholesterol;
   Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. Women's Preventive: Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

- Women's contraceptives, sterilization procedures, and counseling: This includes Generic and single-source brand name drugs for oral contraceptives, as well as injectable contraceptives and patches at no cost share. Please use your Prescription Drug benefit when available. Contraceptive services such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Note: Multi-source brand drugs will be covered under the Prescription Drug benefit and apply the applicable cost share.
- Breastfeeding support, supplies and counseling; Covered in full when received from an in-network provider.
- Screenings and/or counseling, where applicable, for Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

You may call Customer Service using the number on your ID card for additional information about these services.
**Note:** The Plan provides benefits, beyond those currently required by state or federal law, for the following preventive and well-care services which are not subject to the Plan Deductible.

- Routine physical examinations;
- Annual mammograms for women, including an additional radiologic procedure when recommended by a provider because the results of the initial procedure are not definitive;
- Annual prostate specific antigen testing and digital rectal examinations for men;
- Annual gynecological examinations, including routine pelvic and clinical breast examinations performed by a physician, certified nurse practitioner or certified nurse midwife;
- Cholesterol testing and related liver function tests;
- Diabetic Testing: Hemoglobin A1C test (also called HbA1c, glycated hemoglobin or glycohemoglobin)
- Tetanus booster, as necessary;
- Colonoscopies, sigmoidoscopies and fecal occult blood test;
- Blood lead screening;

**Radiation Therapy** The Plan provides benefits for radiation therapy.

**Reconstructive Surgeries, Procedures and Services** The Plan provides benefits for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met.

Reconstructive surgeries, procedures and services must be:

1. necessary due to accidental injury; or
2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary Health Care to restore or improve a bodily function, or
4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate
5. for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Certificate.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to the Contract Administrator's Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on the Contract Administrator's Medical Policy coverage criteria are:

1) Mastectomy for Gynecomastia
2) Mandibular/Maxillary orthognathic surgery
3) Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants
4) Port Wine Stain surgery

**Skilled Nursing Facility** The Plan provides benefits for inpatient skilled nursing facility & inpatient rehabilitation services subject to a combined calendar year limit as described in your Benefit Summary. The Plan does not cover custodial confinement.

**Smoking Cessation** The Plan provides benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. NRT products can include but are not limited to, nicotine patches, gum, or nasal spray. To be eligible for benefits, these products and medications must be prescribed by your physician. The Plan provides benefits for up to two physician office visits per calendar year for follow-up smoking cessation education and counseling. The Plan provides benefits for completing an approved smoking cessation program.

Please see your Benefit Summary for applicable copayment, coinsurance, deductibles, limitations, and maximums that apply.

**Speech Therapy** The Plan provides benefits for speech therapy for the active treatment for correction of an impairment resulting from illness, disease, trauma or congenital anomaly. Benefits are provided for therapy to restore or improve lost function. There must be a reasonable expectation that therapy will result in progressive improvement of the impairment. Benefits are subject to a combined calendar year limit as described on your Benefit Summary. Services are covered only when provided by a licensed professional acting within the scope of his/her license for an active course of treatment medically appropriate for the diagnosed condition.

**Sterilizations** The Plan provides benefits for voluntarily induced sterilization. Reversal of sterilization is not covered.

**Surgical Services** Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care.

For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Anthem surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or call the number on the back of your Identification Card.

**Telemedicine** Benefits are provided for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation.

# Section Five
# Exclusions

This section, along with the Covered Services section, explains the types of health care services for which the Plan will and will not provide benefits. The exclusions listed below are in addition to those set forth elsewhere in this Plan Document. In addition to the exclusions listed below, any service not listed or specifically identified as a covered service is presumed not covered. Charges you pay for services related to non-covered services do not count toward any deductible, coinsurance, or out-of-pocket limits.

**Acupuncture** The Plan does not provide benefits for acupuncture.

**Alternative Medicines or Complementary Medicines** The Plan does not provide benefits for alternative or complementary medicine. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established, as determined by the Contract Administrator's Medical Director. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reike therapy, herbal, vitamin or dietary products or therapies (except as otherwise provided in the Covered Services section), naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

**Artificial Hearts** The Plan does not provide benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a heart transplant.

**Asthma Education** The Plan does not provide benefits for asthma education programs.

**Benefits Available from Other Sources** The Plan does not provide benefits for any services to the extent that there is no charge to you or to the extent that you can recover or have recovered expenses through federal, state, county, or municipal law, or from a third party. This is the case even if you waive or fail to assert your rights under these laws. However, this exclusion does not apply to Maine Care (Medicaid).

**Biofeedback** The Plan does not provide benefits for biofeedback.

**Blood** The Plan does not provide benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

**Commercial Weight Loss Programs** – The Plan does not provide benefits for weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in the Plan Document. This exclusion includes, but is not limited to, commercial weight loss programs (for example Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity.

**Cosmetic Services** The Plan does not provide benefits for cosmetic services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. Examples of cosmetic services include, but are not limited to: surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery

and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

**Custodial Care** The Plan does not provide benefits for services, supplies or charges for custodial care, domiciliary or convalescent care, whether or not recommended or performed by a professional.

**Dental Services** The Plan does not provide benefits for orthognathic surgery, dentistry, dental surgery, dental implants or any other services unless specifically listed as covered in the Covered Services section.

**Department of Veterans Affairs** The Plan does not provide benefits for any treatments, services, or supplies provided to veterans by the Department of Veterans Affairs, its hospitals, or facilities if the treatment is related to your service connected disability.

**Experimental/Investigational Services** The Plan does not provide benefits for any drugs, supplies, providers, medical, or health care services that are experimental/investigational. This exclusion includes the cost of all services from a provider or professional including the cost of all services while you are an inpatient receiving an experimental/investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), any device to which the FDA has limited access or otherwise limited approval, and any services involved in clinical trials are considered experimental/investigational.

**Facilities of the Uniformed Services** The Plan does not provide benefits for any treatments, services, or supplies provided by or through any health care facility of the uniformed services. This exclusion does not apply if you are a military dependent or retiree.

**Family Planning Services** The Plan does not provide benefits for services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.

**Felony or Illegal Occupation** The Plan does not provide benefits for any expense for illness or injury caused by or contributed to by engaging in an illegal occupation or by committing or attempting to commit a felony.

**Food or Dietary Supplements** – The Plan does not provide Benefits for nutritional and/or dietary supplements, except as provided in the Plan Document or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

**Genetic Testing and Counseling** The Plan does not provide Benefits for genetic counseling, except as required by law. The Plan does not provide Benefits for genetic testing, except in accordance with the Contract Administrator's Medical Policy. Medical technology is constantly evolving and medical policies are subject to change without notice.

**Government Institutions** The Plan does not provide benefits for any services provided to you by any institution that is owned or operated by the federal government or any state, county, or municipal government.

**Health Club Memberships** – The Plan does not provide Benefits for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for

activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

**Hearing Care** The Plan does not provide benefits for hearing examinations except for screening members under the age of 19 years or when related to injury or disease. Please see Hearing Care in the Covered Services section for benefits for hearing aids.

**Infertility** The Plan does not provide benefits for diagnostic services, procedures, treatment or other services intended to result in pregnancy. This exclusion also applies to drugs used to enhance fertility. The Plan does not provide benefits for costs associated with achieving pregnancy through surrogacy.

**Leased Services and Facilities** The Plan does not provide benefits for any health care services or facilities that are not regularly available in the provider you go to, that the provider must rent or make special arrangements to provide, and that are billed independently.

**Maintenance Therapy** The Plan does not provide benefits for maintenance services, treatments or therapy.

**Major Disaster, Epidemic, or War** In the event that covered services are not available as a result of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond the Plan Administrator's control, the Plan Administrator will make a good faith effort to provide or arrange for covered services. The Plan Administrator will not be responsible for any delay or failure to provide services due to lack of available facilities or personnel as a result of such events. Benefits are not provided for any disease or injury that is a result of war, declared or undeclared, or any act of war.

**Massage Therapy** – The Plan does not provide Benefits for massage therapy when services are not part of an active course of treatment and are not performed by a Covered Professional (Please see definition of Covered Professional.). Services by a massage therapist are not covered.

**Medically Unnecessary Services** The Plan does not provide benefits for any treatment, services, or supplies that do not meet the definition of medically necessary health care.

**Medicare** The Plan does not duplicate benefits in situations where Medicare would have primary liability for health care costs under federal Medicare Secondary Payer regulations. If you are enrolled in Medicare Part A, Part B, and/or Medicare Part D and Medicare is the primary payer, benefits may only be provided for balances remaining after Medicare has made payment. If you are eligible for premium free Medicare Part A, and Medicare would be the primary payer, benefits may be paid as if Medicare had made their primary payments for Medicare Part A, Part B, and/or Part D, as applicable, even if you fail to exercise your right to premium free Medicare Part A coverage.

**Mental Health, Substance Abuse Treatment and Lifestyle Services** The Plan does not provide benefits for any of the following services or any services relating to:

- Smoking clinics;
- Sensitivity training;
- Encounter groups;
- Educational programs except as indicated in the Covered Services section;
- Marriage, guidance, and career counseling;
- Codependency;
- Adult Children of Alcoholics (ACOA);
- Pain control (except as required by law for hospice care services);

- Activities whose primary purpose is recreational and socialization.

**Miscellaneous Expenses** The Plan does not provide benefits for provider or professional charges to provide required information to process a claim or application for coverage. Benefits are not provided for any additional costs associated with an appeal of a claim decision.

**Missed Appointments** The Plan does not provide benefits for missed appointments. Providers and/or professionals may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No benefits are available for these charges. You are solely responsible for these charges.

**Orthognathic Surgery** The Plan does not provide benefits for orthognathic surgery, except as stated in the Covered Services, Reconstructive Surgeries, Procedures and Services section.

**Orthotic Devices** The Plan does not provide benefits for orthotic devices unless stated as covered in the Covered Services section of this Plan Document.

**Personal Comfort Items** The Plan does not provide benefits for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

**Physical and Occupational Therapy** The Plan does not provide benefits for massage therapy, treatment such as paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

**Prescription Drugs** The Plan does not provide benefits for the following:

- Any refill in excess of the number specified by the physician or for refills dispensed after one year from the date of original prescription order;
- Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes;
- Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form;
- Prescription drugs for the treatment of weight reduction/anorectics;
- Medication that is taken by or administered to an inpatient;
- Experimental or investigational drugs or any Food and Drug Administration (FDA) Treatment Investigational New Drugs (IND), unless the intended use of the drug is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug is recognized in one of the standard reference compendia or in peer-reviewed medical literature;
- Disposable supplies such as alcohol, cotton balls, or bandages used to administer medications;
- Prescription drugs dispensed by a physician;
- Prescription drugs used to enhance fertility;
- Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by the Plan for medically accepted indications or as required by law.

**Prostheses** The Plan does not provide benefits for dental prostheses, or prosthetic devices to replace, in whole or in part, an arm or leg that are designed exclusively for athletic purposes

**Refractive Eye Surgery** The Plan does not provide benefits for refractive eye surgery, such as radial keratotomy, for conditions that can be corrected by means other than surgery.

**Reversal of Sterilization** The Plan does not provide benefits for services to reverse voluntarily induced sterility.

**Routine Foot Care** The Plan does not provide benefits for any services rendered as part of routine foot care.

**Services After Your Plan Terminates** The Plan does not provide benefits for services that are provided after your Plan coverage ends, unless otherwise stated in this Plan Document.

**Services Before the Effective Date** The Plan does not provide benefits for any treatment, services, supplies, medical equipment, or prostheses rendered to you or received before your individual effective date of coverage. Services you receive during an inpatient stay that started before your effective date on this Plan are not covered.

**Services by Ineligible Providers or Professionals** The Plan does not provide benefits for services provided by any person or entity that is not an eligible Provider or Professional as described in this Plan Document.

**Services by Relatives or Volunteers** The Plan does not provide benefits for any services provided in any capacity by immediate family members or step-family members, for example, spouse, father, mother, brother, sister, son or daughter. The Plan does not provide benefits for services by volunteers, except as outlined in the Hospice Care Services provision. This provision is not intended to exclude otherwise covered medically necessary services, when furnished by a relative who is a licensed Provider acting within the scope of his/her license.

**Services Not Listed As Covered** The Plan does not provide benefits for any service, procedure, or supply not listed as a covered service in this Plan Document.

**Services Related to Non-Covered Services** The Plan does not provide benefits for services related to any non-covered service or to any complications and conditions resulting from any non-covered service.

**Sex Changes** The Plan does not provide benefits for any services related to any transsexual operation.

**Shoe Inserts** The Plan does not provide benefits for shoe inserts.

**Speech Therapy** The Plan does not provide benefits for maintenance therapy or treatment that is not medically appropriate for the diagnosed condition. The Plan does not provide benefits for treatment of conditions not subject to significant improvement, not designed to restore or improve lost function, or not for active treatment.

**Surrogate Mother Services** – The Plan does not provide Benefits for any services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

**Taxes or Shipping Charges** The Plan does not provide benefits for any expense for taxes or shipping charges.

**Temporomandibular Joint (TMJ) Syndrome Services** The Plan does not provide benefits for surgical and non-surgical examination; diagnosis, including invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment, both medical and surgical, of

temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-covered services include but are not limited to: physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound, or diathermy; behavior modification such as biofeedback, psychotherapy; appliance therapy such as occlusal appliances (splints) or other oral prosthetic devices and their adjustments; orthodontic therapy such as braces; prosthodontic therapy such as crowns, bridgework; and occlusal adjustments.

This exclusion does not apply to services listed as covered in the Dental Services provision.

**Travel Expenses** The Plan does not provide benefits for any travel expenses, whether or not the travel is recommended by a professional.

**Vision Care** The Plan does not provide benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. The Plan does not provide benefits for the prescription, fitting, or purchase of glasses or contact lenses except when medically necessary to treat accommodative strabismus, cataracts, or aphakia.

**Workers' Compensation** The Plan does not provide benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. The Plan does not provide benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, the Plan does provide benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.

The Plan will pay benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met**:

- You are making a claim under the Workers' Compensation Act;
- Your health care coverage is provided through the Plan;
- Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- The Workers' Compensation Board has not made a determination on your claim;
- Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this Plan, as discussed in the Benefit Determinations, Payments and Appeals section.

Provisional benefit payments will end upon the earliest of the following:

- The date the Hearing Officer makes a determination of the work-relatedness of the Plan Participant's injury or illness;
- The date the employer acknowledges that such injury or illness is work-related;
- The date the employer or the Workers' Compensation carrier makes or agrees to make any payment for such injury or illness.

The Contract Administrator will notify the employer's Workers' Compensation carrier of the amount of the provisional payment and will request reimbursement of that amount. If the employer's Workers' Compensation carrier makes any payment to the covered employee after the Contract Administrator makes notification, the employee will be obligated to reimburse the Plan the amount of the provisional payment.

The Right of Subrogation and Reimbursement provision in the Benefit Determinations, Payments and Appeals section applies.

# Section Six
# Benefit Determinations, Payments and Appeals

## Benefit Determinations

The Plan Administrator, the Contract Administrator, or anyone acting on the Contract Administrator's behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms of the Plan. However, the Plan Administrator, the Contract Administrator, or anyone acting on the Contract Administrator's behalf, have complete discretion to determine the administration of your benefits. The determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are medically necessary, investigational/experimental, whether surgery is cosmetic, and whether charges are consistent with the Plan Maximum Allowed Amount. However, you may utilize all applicable complaint and appeal procedures, as outlined later in this section.

You may have some responsibility for the cost of health services under this Plan. Your responsibility may take the form of a coinsurance percentage, a deductible, or a copayment amount. Please see your Benefit Summary for the coinsurance, deductible and copayment amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your coinsurance, deductible, or copayment amount directly to the professional or hospital or other provider of care. If you have coinsurance responsibility that is based on a percentage, you will pay your coinsurance percentage based on the hospital's or provider's discounted charge or negotiated amount, or the Plan Maximum Allowed Amount for professionals.

All benefits for covered services for Network Providers and Professionals will be based on the Plan's Maximum Allowed Amount for Provider and Professional services.

**Note:** Non-network Providers and Professionals can bill you for the difference between the non-network Provider's or Professional's charge and the Plan's Benefit.

The Contract Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, prescription drugs, mental health, behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Contract Administrator's behalf.

### Network Directory

Information about Network Providers is available in the online network directory at the Contract Administrator's website (www.anthem.com). You can find information such as the Provider's location and qualifications. If you don't have access to the website or need help to find a doctor who is right for you, call the Member services number on your ID card. TTY/TDD services also are available by dialing 711. A special operator will contact the Contract Administrator to help with Member needs.

## Benefit Levels

There are two levels of benefits under this Plan:

**Network Providers and Professionals** If your claim from a Network Provider or Professional is approved, the Contract Administrator will pay benefits directly to the Network Provider or Professional.

Except for copayments, deductibles, and coinsurance, you are not required to pay any balances to the Network Provider or Professional for covered services until after the determination is made on the benefits the Plan will pay. Benefits will be paid at the network level of benefits listed on your Benefit Summary. Network providers and professionals have agreed to accept the Plan Maximum Allowed Amount and will not bill Plan Participants for amounts over the Maximum Allowed Amount. The Plan Participant is still, however, responsible for this Plan's deductibles, copayment or coinsurance where applicable.

**Non-Network Providers and Professionals** If you receive covered services or supplies from a provider or professional that does not have a written agreement with the Contract Administrator, a determination of benefits will be based on the provider's eligibility and licensing. If your claim is approved, benefits will be paid at the non-network level of benefits listed on your Benefit Summary. You will be responsible for the difference between the Non-Network Provider's or Professional's charge and the Maximum Allowed Amount, in addition to any applicable copayment, deductible or coinsurance. Non-network Providers and Professionals can bill you for the difference between the Non-Network Provider's or Professional's charge and the Maximum Allowed Amount.

If a network provider or professional of the same specialty is not reasonably accessible as defined by state law, services received from a non-network provider or professional will be paid at the higher level of benefits indicated on your Benefit Summary. In this circumstance, please call the number on the back of your ID card to coordinate care through a non-network provider or professional.

## How Your Deductible Works

Each calendar year before benefits can be paid for most covered services, you must pay your deductible. When you receive covered services during the last three months of the calendar year and charges for these covered services are applied toward that year's deductible, then these same charges will also be applied toward the deductible for the following year.

**Family Deductible** Under family coverage, if total family expenses for covered services exceed two times the individual deductible for the calendar year, then your family deductible under this Plan has been met for the calendar year. In this case, all family members will be eligible for benefits for the rest of the calendar year without meeting further deductibles. One family member may not meet more than the individual amount: the family deductible amount must be satisfied by at least two family members.

## Copayments and Coinsurance

Copayments and coinsurance apply to certain services. Please see your Benefit Summary for copayment amounts and coinsurance amounts and limits. If services are received from a provider or professional that does not have a written participation agreement with the Contract Administrator (Non-Network Provider or Professional) there may be instances in which you may be responsible for any remaining balances beyond the Maximum Allowed Amount.

**Copayments** For some services, your share of the cost includes a fixed dollar payment called a copayment. Copayment amounts do not count toward any deductible or coinsurance amounts under this Plan.

**Coinsurance** For some services, your share of the cost includes a percentage of the cost of covered services. This is the coinsurance amount. Coinsurance payments are subject to an annual dollar limit. Once you pay the annual coinsurance limit, the Plan pays benefits at 100% of the Maximum Allowed Amount for covered services for the rest of the calendar year.

**How Your Coinsurance Limit Works** Under family coverage, if the total family coinsurance expenses equals two times the individual coinsurance limit for the calendar year, your family coinsurance limit under this Plan has been met for the calendar year. In this case, all family members will be eligible for Benefits for the rest of the calendar year without paying further coinsurance.

## Annual Out-of-Pocket Limits

Your annual out-of-pocket expenses for your deductible and coinsurance are limited. Please refer to your Benefit Summary for the annual out-of-pocket limit that applies. Once you reach the annual out-of-pocket limit, no further deductibles, copayments or coinsurance apply for the remainder of the calendar year. Note: Utilization Management penalties and charges by Non-Network Providers or Professionals in excess of the Maximum Allowed amount do not count towards the Out-of-Pocket limit.

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## Benefit Maximums

Specific benefit maximums for each Plan Participant apply to certain services. These maximums are listed on your Benefit Summary or in this Plan Document.

## Plan Changes

The Plan Sponsor may change this Plan at any time and from time to time in its sole discretion provided the changes are in accordance with all applicable laws.

## Compliance with Laws

If applicable federal laws or the relevant laws of the state of Maine that are not preempted by federal law change, the provisions of this Plan will automatically change to comply with those laws as of their effective dates. Any provision of this Plan that does not conform with such applicable federal or state law will not be rendered invalid, but will be construed and applied as if it were in full compliance.

## Confidentiality

Any information pertaining to your diagnosis, treatment or health obtained from either your physician, provider or you will be held in confidence. The Plan Administrator and Contract Administrator may use or disclose this information only to the extent required or permitted by law. Please refer to the Plan's privacy protection annual notice for privacy policies and procedures.

## Statements and Representations

The statements you make on your application for coverage under this Plan are representations and not warranties.

## Severability

If any term or provision in this Plan Document is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

# Benefit Payments

## Claims Procedure

**How to Claim Benefits** In most instances, providers and professionals will file your claims with the Contract Administrator. However, you may need to submit a claim for reimbursement for services from non-network providers and professionals.

To receive claim forms, contact your employer or call the Customer Service Department at the telephone number on your ID card. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

**Time Limit for Filing Claims** The Contract Administrator must receive proof of a claim for reimbursement for a Covered Service no later than 365 days after that service is received. There may be special circumstances which would prevent a claim from being submitted within the 365-day time limit. Claims denied for timely filing may be reviewed through the Appeal process, which will consider whether the claim was filed as soon as reasonably possible

**Releasing Necessary Information** Providers and professionals often have information needed to determine your coverage. As a condition for receiving benefits under this Plan, you or your representative must provide all of the medical information needed to determine your eligibility for coverage or to process your claim.

**Non-Transfer of Benefits** Your right to benefits under this Plan is personal to you. You cannot assign or transfer this right to any other person.

**Assignment of Payments** You may assign payments for covered services to the provider or professional who provided the care.

**Non-Compliance** If the Plan Administrator does not enforce compliance with any provision of this Plan Document, the Plan Administrator has not waived compliance and is not required to allow non-compliance of that provision or any other provision at any time, in any case.

**Examination of Insured** To ensure that all claims are valid, the Contract Administrator may require the Plan Participant to have a physical or mental examination at the Plan's expense.

## Claims Payment

This subsection explains how benefits for covered services will be paid. You will receive maximum benefits when you receive services from network providers and professionals. The Plan reserves the right but is not required to pay benefits to another person unless so ordered by a court of competent jurisdiction. You have the right to appeal as outlined later in this section.

### Payment of Provider Services

#### Maximum Allowed Amount

This section describes how the Contract Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-Network Providers is based on your Contract's Maximum Allowed Amount for the Covered Service that you receive. Please see the BlueCard Program section for additional information.

The Maximum Allowed Amount for your Contract is the maximum amount of reimbursement the Contract Administrator will allow for services and supplies:

- that meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- that are Medically Necessary Health Care; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges unless the Contract Administrator has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. This amount can be significant.

When you receive Covered Services from a Provider, the Contract Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The Contract Administrator's application of these rules does not mean that the Covered Services you received were not Medically Necessary Health Care. It means the Contract Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, the Contract Administrator may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

**Provider Network Status**
The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network, or who has a participation contract with the Contract Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for your Contract is the rate the Provider has agreed with the Contract Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Contract Administrator and are not in any of the Contract Administrator's networks are Non-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

The Maximum Allowed Amount for your Contract will be one of the following as determined by the Contract Administrator:

1. An amount based on the network or non-network provider fee schedule/rate (as required by law), which the Contract Administrator has established in their discretion, and which they reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Contract Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same

services or supplies, and other industry cost, reimbursement and utilization data or

2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

**Providers who are not contracted for this product, but contracted for other products with the Contract Administrator are also considered Non-Network. For your Contract, the Maximum Allowed Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between the Contract Administrator and that Provider specifies a different amount.**

Unlike Network Providers, Non-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges unless the Contract Administrator has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. This amount can be significant. Choosing a Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Network Provider or visit the Contract Administrator's website at www.anthem.com.

Customer Service is also available to assist you in determining your Contract's Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for Customer Service to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

**For Prescription Drugs:** The Maximum Allowed Amount for prescription drugs is the amount determined by the Contract Administrator using prescription drug cost information provided by the pharmacy benefits manager (PBM).

**Member Cost Share**
For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Maximum may vary depending on whether you received services from a Network or Non-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Non-Network Providers. Please see the Benefit Summary for your cost share responsibilities and limitations, or call Customer Service to learn how this Contract's benefits or cost share amounts may vary by the type of Provider you use.

The Plan will not provide any reimbursement for non-covered services. You will be responsible for the total

amount billed by your Provider for non-covered services, regardless of whether such services are performed by a Network or Non-Network Provider. Both services specifically excluded by the terms of your plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower Network cost sharing amount when you use a Non-Network Provider. For example, if you go to a Network Hospital or Provider Facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, you will pay the Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge unless the Contract Administrator has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies.

**Authorized Services**

In some non-emergency circumstances, such as where there is no Network Provider available for the Covered Service, the Contract Administrator may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Network Provider. In such circumstance, you must contact the Contract Administrator in advance of obtaining the Covered Service. If the service is authorized as Covered Service so that you are responsible for the Network cost share amounts, you may not be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge unless the Contract Administrator has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. Please contact Customer Service for Authorized Services information or to request authorization.

Example:
You require the services of a specialty Provider; but there is no Network Provider for that specialty in your service area. You contact the Contract Administrator in advance of receiving any Covered Services, and they authorize you to go to an available Non-Network Provider for that Covered Service and agree that the Network cost share will apply.

Your plan has a $45 Copayment for Non-Network Providers and a $25 Copayment for Network Providers for the Covered Service. The Non-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because the Contract Administrator authorized the Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and the Plan will be responsible for the remaining balance.

**Out-of-State Providers and Professionals** Out-of-state providers may bill you any balance remaining after the benefit has been paid based on the maximum allowable amount, except as otherwise provided under the BlueCard program.

## Inter-Plan Programs

**Out-of-Area Services**

Anthem BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem BCBS service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem BCBS and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem BCBS service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Anthem BCBS payment practices in both instances are described below.

## BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem BCBS will remain responsible for fulfilling Anthem BCBS contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Anthem BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Anthem BCBS.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem BCBS uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if **we** pay the healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, **we** may collect such amounts directly from you. You agree that **we have** the right to collect such amounts from you.

### Non-Participating Healthcare Providers Outside Anthem BCBS Service Area

Your Liability Calculation
When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

## Acknowledgement of Understanding

By accepting this policy you expressly acknowledge your understanding that this policy constitutes a benefit plan provided through your employer by agreement with the Contract Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The license permits the Contract Administrator to use the Blue Cross and Blue Shield service marks in the State of Maine, and the Contract Administrator is not contracting as the agent of the Association.

You also acknowledge that you have not accepted this policy based upon representations by any person other than the Contract Administrator and that no person, entity, or organization other than the Contract Administrator will be held accountable or liable to you for any of the Contract Administrator's obligations created under this policy. These acknowledgements in no way create any additional obligations whatsoever on the part of the Contract Administrator other than those set forth in this policy.

**Hospitals Outside of the United States** The Plan provides benefits for inpatient and outpatient services in a foreign hospital. If you obtain covered services outside of the United States, in most cases you will have to pay your bill when you leave the hospital. Please refer to the Utilization Management section for details pertaining to authorizations.

When you return home, send the following to the Contract Administrator with your claim form:

- A statement of the nature of the illness or injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your contract number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

When this information is received, you will be reimbursed for covered services according to the terms of this Plan.

## Pharmacy Benefit Management

The Pharmacy Benefits available to you under this Plan are managed by a pharmacy benefits management (PBM) company with which the Contract Administrator contracts to manage your Pharmacy Benefits. The PBM has a nationwide network of retail pharmacies, a mail service Pharmacy, and clinical services that include tier management.

The management and other services provided include, among others, making recommendations to, and updating, the tier listing and managing a network of retail pharmacies and operating a mail service Pharmacy. The PBM, in consultation with the Contract Administrator, also provides services to promote and enforce the appropriate use of Pharmacy Benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

**Payment for Prescription Drug Claims**

To obtain Benefits for Prescription Drugs, present your identification card to any Pharmacy that has an agreement with the PBM, in this or any other state. You must pay the applicable amounts shown on your Benefit Summary. The participating Pharmacy will submit the claim for you and the PBM will directly pay the Pharmacy the balance due. Please call Customer Service at the telephone number on your ID card if you have questions about the participation status of a Pharmacy.

If you use a Pharmacy that does not have an agreement with the PBM, or if you do not use your identification card, you must pay the Pharmacy the entire cost for the prescription and submit a claim form for reimbursement. Claim forms are available by contacting a Customer Service Representative.

If you receive Prescription Drugs from a non-participating Pharmacy or if you do not use your identification card, you may receive a reduced benefit. The Plan will reimburse you based on the amount the Plan would have paid to a participating Pharmacy less your share of the cost.

Your financial responsibility (Copayments) will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Manager from drug manufacturers, or similar vendors or funds received by the plan from the Pharmacy Benefits Manager.

Your prescription drug Copayment will be the lesser of your scheduled Copayment amount or the retail price charged for your prescription by the Pharmacy or the Pharmacy Benefits manager that fills your prescription.

No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Copayment for which you are responsible.

**For Prescription Drugs:** The Maximum Allowed Amount for prescription drugs is the amount determined by Anthem using prescription drug cost information provided by the pharmacy benefits manager (PBM).

**Prescription Drugs By Mail**
To obtain Benefits for Prescription Drugs through the mail order Pharmacy, complete a mail order Pharmacy form, available through the Contract Administrator's Customer Service Department, and mail it with your prescription. You must enclose the applicable Copayment amount indicated on your Benefit Summary.

## Coordination of Benefits

All benefits of the Plan are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to members covered by more than one plan. It helps keep down the cost of health coverage by ensuring that the total benefits you receive from all plans does not exceed the cost of covered services.

COB sets the payment responsibilities for any plan that covers you, such as:

- Group, individual (also known as non-group), self-insured Plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- Other insurance that provides medical benefits.

The plan with primary responsibility provides full benefits for covered services as if there were no other coverage. The plan with secondary responsibility may provide benefits for covered services in addition to those of the primary plan. When there are more than two plans covering the person, the plan may be primary to one or more plans, and may be secondary to another plan or plans. All benefits are limited to the Plan maximums or to the Maximum Allowed Amount for the services you receive.

When you have duplicate coverage:

- If the other plan does not contain a COB clause or does not allow coordination of benefits with this Plan, the benefits of that plan will be primary;
- If both plans contain a COB clause allowing the coordination of benefits with this Plan, the Contract Administrator will determine benefit payments by using the first of the following rules that applies:

1. **Non-Dependent/Dependent** The benefits of the plan that covers you as an employee will be determined before the benefits of the plan that covers you as a dependent are determined.
2. **Dependent Children (Parents Not Legally Separated or Divorced)** For claims on covered dependent children, the plan of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the plan that has covered one parent longer will be primary over the plan that has covered the other parent for a shorter period. If the other plan does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the plans do not agree on the order of benefits, the rule in this Plan will determine the order of benefits.
3. **Dependent Children (Parents Legally Separated or Divorced)** In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of that parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent's health care expenses, the coverage of that parent's plan will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.
4. **Active/Inactive Employee** The benefits of a plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other coverage does not include this provision, and as a result, the plans do not agree on the order of benefits, rule six applies.
5. **Continuation of Coverage** If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another plan, the benefits of the plan covering the person as an employee or employee, or as the dependent of an employee or employee, will be primary. The benefits of the continuation coverage will be secondary. If the other plan does not include this provision regarding continuation coverage, rule six applies.
6. **Longer/Shorter Length of Coverage** If none of the rules above determines the order of benefits, the benefits of the plan that has covered the employee or eligible person longer will be determined before those of the plan that has covered the person for a shorter period.

The Contract Administrator reserves the right to:

- Take any action needed to carry out the terms of this section;
- Exchange information with an insurance company or other party;
- Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when the Contract Administrator decides they're necessary without notifying the covered persons.

## Disability

If your group health coverage terminates under this Plan while you are totally disabled, benefits for covered services directly relating to the condition causing total disability remain available to you until you are no longer disabled, you reach any contract maximums, you are discharged as an inpatient and you are no longer disabled, or six months from the termination of your group contract, whichever occurs first. If you have replacement coverage, the replacement coverage will pay as primary coverage during this time, and the Plan will pay as secondary coverage for the covered expenses directly relating to the condition causing total disability.

Under the Plan, disabled means:

- If you were employed, you are unable to work in your regular and customary occupation because of illness or injury;
- If you were not gainfully employed, you are unable to engage in most normal activities of a person of like age in good health.

The Plan's coverage of losses during your total disability has the same limits that apply to Plan Participants who are not disabled.

## Special Information If You Become Eligible For Medicare

You must notify the Contract Administrator if you become eligible to enroll in premium free Medicare Part A. Failure to notify the Contract Administrator could result in retroactive benefit adjustments if Medicare would have been or is the primary payer. You may choose to continue your coverage once you are eligible to enroll in premium free Medicare Part A, Medicare Part B and Medicare Part D coverage. However, your Plan will not provide benefits that duplicate any benefits payable under Medicare Part A, Part B, or Medicare Part D, as applicable. This is true even if you fail to exercise your rights to enroll in premium free Medicare Part A, Medicare Part B, and Medicare Part D coverage. If you become eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare Supplement plans have limited enrollment periods, it is important to evaluate these plans as soon as you are eligible for Medicare.

**Important Note:** If the active employee or dependent spouse chooses Medicare as their primary insurance, no coverage is available under this Plan.

## Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with Maine Automobile Dealers Association Insurance Trust Group Medical Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Maine Automobile Dealers Association Insurance Trust Group Medical Plan has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, and keep this coverage, your current Maine Automobile Dealers Association Insurance Trust Group Medical Plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Maine Automobile Dealers Association Insurance Trust Group Medical Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Maine Automobile Dealers Association Insurance Trust Group Medical Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the Maine Automobile Dealers Association Insurance Trust at (207) 623-3882
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Maine Automobile Dealers Association Insurance Trust Group Medical Plan changes. You also may request a copy of this notice at any time.

## For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

## Medicare and End-Stage Renal Disease

When a Plan Participant who is under age 65 becomes eligible for Medicare solely due to End Stage Renal Disease (ESRD), this Plan will be primary only during the first 30 months of Medicare coverage. Thereafter, the Plan will be secondary to Medicare coverage. If an employee or dependent is under age 65 when Medicare eligibility is due solely to ESRD, and he/she subsequently attains age 65, this Plan will be primary for a full 30 months from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary. If an employee or dependent is age 65 or over, working and develops or is undergoing treatment for ESRD, the Plan will be primary for a full 30 months from the date of ESRD disability. Thereafter, Medicare will become primary and the Plan will be secondary.

**Note:** When the Plan Participant is a COBRA beneficiary, Medicare is the primary payer.

## Right of Subrogation and Reimbursement

If the Plan pays benefits to or on behalf of a covered employee or dependent, such Plan Participant or third party that was paid must reimburse the Plan if:

- All or some of the expenses were not paid by the Plan Participant or did not legally have to be paid;
- All or some of the payment made by the Plan exceeded the benefits under this Plan;
- All or some of the expenses were recovered from or paid by a source other than this Plan. This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions.

In the event of an accident or illness which may give rise to a right of recovery by a Plan Participant from a third party, the right to receive benefits under this Plan shall be conditioned upon the Plan Participant, or their personal representatives, delivering to the Plan a signed agreement to repay amounts recovered from a third party, for the full amount of the benefits paid by the Plan. The Plan Participant is required to notify the Plan of all claims made against third parties and any settlements, payments, judgments, or other recoveries based on such claims. Plan Participants must also notify all third parties against which claims are made of the rights of the Plan to recover all amounts paid by the Plan on behalf of the Plan Participant as described herein.

Upon any recovery, whether by judgment, suit, compromise, settlement or otherwise, made by a Plan Participant from any person(s), party or parties, insurance company, firm, corporation, or other entity, the Plan Administrator, with or without filing a lien, shall be entitled to immediate reimbursement, as described above, to the full extent of benefits paid by the Plan. Such reimbursement shall be first paid without regard to whether such payments are designated as payment for pain and suffering, loss of income, medical benefits, or other specified damages and without regard to whether the Plan Participant has been made whole. Such reimbursement shall not be subject to reduction or offset by reason of attorneys fees.

By accepting benefits under this Plan, a Plan Participant agrees to reimburse the Plan Administrator for benefits paid in the event of such recovery. The Plan will be subrogated to all rights the Plan Participant may have against that third party. If reimbursement is due from another person or organization, the Plan Participant agrees to help the Plan Administrator receive reimbursement. Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

Reimbursement will equal the amount the Plan paid in excess of the amount it should have paid. In the case of recovery from or payment by a source other than this Plan, reimbursement will equal the amount of the recovery or payment up to the amount the Plan paid. Any recovery that is subject to reimbursement is an asset of the Plan for which the Plan Participant and all persons exercising control over such Plan assets will be deemed a fiduciary to the Plan with respect to those Plan assets and shall be responsible for preserving and returning such assets to the Plan.

The Plan may coordinate benefits with automobile, homeowners, general liability and any other third party liability policies including uninsured or underinsured motorist coverage. If an individual retains an attorney in regard to a claim against a third party, the attorney's fee is the individual's responsibility and cannot be deducted from the recovery amounts paid to the Plan.

If a Plan Participant, or any other person, or organization that was paid, does not promptly reimburse the full amount due to the Plan, the Plan Administrator may reduce the amount of any future benefits that are payable under the Plan. The reduction will equal the amount of the required reimbursement. The Plan or the employer may have other rights in addition to the right to reduce future benefits.

## Complaints

The Contract Administrator's Customer Service Representatives are ready to help Plan Participants resolve complaints about claims processing, benefit choices, enrollment, or health care given to you by your Provider. A Customer Service Representative may need to send your complaint to another area for response. The staff that gets the Plan Participant complaint will review and quickly give a finding to the Plan Participant on the complaint. The Contract Administrator will make a good faith effort to get all information quickly. Your Provider may ask by phone, fax or in writing for the Contract Administrator to reconsider an adverse determination within one working day after the request is received. The review will be done by the person who made the adverse determination or by a peer if the first person cannot be on hand within one working day.

For first Utilization Review findings, the Contract Administrator will make the decision and will let the Covered Person and their Provider know the result within 2 working days after getting all needed information on a proposed hospital stay, treatment or service that calls for a review decision.

If more information is needed, a final decision will be made within thirty (30) days after the added information is received. If your complaint is not resolved to your satisfaction, you may seek help through the Appeal process outlined below. Enrollees may begin a first level Appeal at any time.

### Complaints Requiring Immediate Intervention

If you are not happy with a finding on a service, the Contract Administrator will work with the health care provider to answer quickly to the concern. This will happen before the need for services, when possible, or within 48 hours after receiving all necessary information.

Concurrent review decisions.
The Contract Administrator will make the decision within one working day after getting all needed information. In the case of a decision to approve a longer stay or more services, the Contract Administrator notifies the Plan Participant and the Provider rendering the service within one working day. The written

notice will include the number of added days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, the Contract Administrator notifies the Plan Participant and the Provider rendering the service within one working day. The service will continue without liability to the Plan Participant until the Plan Participant has been told of the finding.

Expedited Appeals.
The Contract Administrator has a written process for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously threaten the life or health of a Plan Participant or would risk the Plan Participant's ability to get back maximum function. An expedited appeal will be available to, and may be requested by, the Plan Participant or the Provider acting for the Plan Participant.

Expedited appeals will be reviewed by a clinical peer or peers. The clinical peer/s will not have been part of the first adverse determination.

The Contract Administrator will provide expedited review to all requests for a hospital stay, availability of care, continued stay or health care service for a Plan Participant who has received emergency services but has not been discharged from a facility.

In an expedited review, all needed information, including the Contract Administrator's finding, will be shared between the Contract Administrator and the Plan Participant or the Provider acting for the covered person by telephone, facsimile, electronic means or the quickest method available.

In an expedited review, the Contract Administrator will make a decision and notify the Plan Participant and the Provider acting for the Plan Participant by phone as quickly as the Plan Participant's medical condition requires, but not more than 72 hours after the review is begun. If the expedited review is a concurrent review decision of emergency services or of an initially authorized hospital stay or course of treatment, the service will be continued without liability to the Plan Participant until the Plan Participant has been notified of the finding.

If the first notice was not in writing, the Contract Administrator will confirm its finding about the expedited review in writing within 2 working days of providing notice of that finding.

**Appeals**

**Level One Appeal Process**
You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Contract Administrator's Appeals Department. An Appeal may be done orally or in writing and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. The Contract Administrator has the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

**On Appeal, the file will be reviewed. Appeals will be reviewed by an appropriate peer or peers who have not been involved with a prior finding. More information may be submitted by or for the Plan Participant, any treating physician, or the Contract Administrator. A finding will be made within thirty (30) days after the Contract Administrator receives the request for an Appeal.**

**The decision will include:**

- The names, titles and information that qualifies the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's request for an Appeal;
- The reviewers' finding in clear terms and the reason in enough detail for the Covered Person to respond to the health carrier's finding;
- A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Plan Participant. Where a Plan Participant had already sent in a written request for the review criteria used by the Contract Administrator in giving its first Adverse Determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
- The notice must advise of any additional appeal rights, and the process and time limit for exercising those rights. Notice of external review rights must be provided to the Enrollee and a description of the process for sending in a written request for second level grievance review.

When the finding is made, if the Plan Participant, or Plan Participants' representative, does not agree with the finding, they may submit a voluntary second level Appeal to the Contract Administrator, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against the Contract Administrator. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000.**

**If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at the Plan's expense by conference call, video conferencing or other appropriate technology to present your concerns with our adverse determination.**

On a Level Two Appeal, the entire record will be reviewed.

Appeals of a clinical nature will be reviewed by an appropriate peer or peers who have not been involved with the prior finding. Additional information may be sent in by or for the Plan Participant, any treating Physician, or the Contract Administrator. You or your representative may meet with the review panel. If you do not request to meet in person, the decision for second level grievance reviews will be made within 30 calendar days. If you do request to appear in person, the review will be done within forty-five (45) days after the Contract Administrator receives the Plan Participant's Level Two Appeal. A written decision will be sent to the Plan Participant within five (5) working days of the review. Once a final decision has been made by the Second Level Appeal panel, the Plan Participant may then ask for an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Plan.

In any Appeal under this procedure in which a professional medical opinion about a health condition is an issue, you may have the right to an independent second opinion, of a provider of the same specialty, paid for by the plan.

Upon the request of a Plan Participant, the Contract Administrator shall provide to the Plan Participant all information that was used for that finding that is not confidential or privileged.
A Plan Participant has the right to:

- Attend the second level review;
- State his or her case to the review panel;
- Submit added material both before and at the review meeting;
- Ask questions of any employee in the meeting; and
- Be assisted or represented by a person of his or her choice.

**External Review Process**

Your representative is a person who has your written consent to represent you in an external review; a person authorized by law to give consent to request an external review for you; or a family member or your treating physician when you are unable to provide consent to request an external review.

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by the Contract Administrator, you may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity and findings regarding experimental or investigational services. An adverse health care treatment decision is a decision made by the Contract Administrator or on behalf of the Contract Administrator denying payment. The request must be made within 12 months of the date the Plan Participant has received the final adverse health care treatment decision of the Level One or Voluntary Level Two Appeal panel.

You or your representative may not request an external review until you have completed Level One of the internal Appeals process unless:

- The Contract Administrator did not make a decision on an Appeal within the time period required or has failed to follow all the requirements of the appeal process as state and federal law require, or the Plan Participant has asked for an expedited external review at the same time as applying for an expedited internal appeal;
- The Contract Administrator and you both agree to bypass the internal Appeals process;
- The life or health of the Plan Participant is at risk;
- The Plan Participant has died; or
- The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written finding must be made by the independent review organization within thirty (30) days after receipt of a completed request for external review from the Bureau of Insurance.

Expedited External Review. An external review finding must be made as quickly as a Plan Participant's medical condition requires but no more than 72 hours after the completed request for external review is received if the 30-day time frame above would risk the life or health of the Plan Participant or would put the Plan Participant's ability to get back maximum function at risk.

**An external review finding is binding on the Plan. You, or your representative, may not file a request for a second external review involving the same adverse health care treatment decision for which you have already received an external review decision.**

## Legal Action Against The Plan

No legal action may be brought against the Plan until the Plan Participant or the Plan Participant's authorized representative has exhausted the Level One Appeal Process outlined above. Any action must be initiated within three (3) years from the date of issuance of the adverse Level One Appeal Process decision

# Section Seven
# Definitions

This section explains the meaning of some of the words in this Plan Document. Other words may be defined in the text.

**Accident** An unforeseen or unexplained sudden injury occurring by chance, without intent or volition.

**Accident Care** Treatment of an accidental bodily injury sustained by the Plan Participant that is the direct cause of the condition for which Benefits are provided and that occurs while the insurance is in force.

**Ambulatory Surgical Facility** A facility that meets both of the following requirements:
- Licensed as an ambulatory surgery center, or is Medicare certified; and
- Meets the Contract Administrator's standards for participation.

**Amendment** An addition, change, correction, or revision to the terms and conditions of the Plan.

**Annual Out-of-Pocket Limit** The limit on the deductible and coinsurance you pay each Benefit Year. After you meet the annual out-of-pocket limit, you pay no further deductible or coinsurance for most services.

**Annual Renewal Date** The date set by the Plan Administrator on which the Plan renews each year.

**Appeal** A request for a review of an initial decision or a Level One Appeal Process decision.

**Applied Behavior Analysis** The design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

**Autism Spectrum Disorder** Any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

**Benefit Year** For the purposes of this Plan, benefit payments (including application of deductibles and out-of-pocket maximums) are determined on a calendar year basis.

**Benefits** Payments made on your behalf under this Plan.

**Calendar Year** The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding calendar year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first. For the purposes of this Plan, benefit payments (including application of deductibles and out-of-pocket maximums) are determined on a calendar year basis.

**Chiropractor** A person who is licensed to perform chiropractic services, including manipulation of the spine.

**Coinsurance** The percentage you pay toward the cost of some covered services.

**Community Mental Health Center** An institution that meets both of the following requirements:
- Licensed as a comprehensive level community mental health center; and
- Meets the Contract Administrator's standards for participation.

**Contract** This Plan Document, any amendments, riders, or attached papers; the Administrative Services Agreement; your application; and the Benefit Summary.

**Contract Administrator** Anthem Blue Cross and Blue Shield and its designated affiliates.

**Copayment** A fixed dollar amount required to be paid by each Plan Participant for certain covered services under this Plan. Please refer to your Benefit Summary for specific information.

**Cosmetic Services** Medical/surgical procedures or services intended solely to change or improve appearance or to treat emotional, psychiatric, or psychological conditions.

**Covered Service** Services, supplies or treatment as described in this Plan Document. To be a Covered Service the service, supply or treatment must be:
a. Medically Necessary or otherwise specifically included as a benefit under this Plan.
b. Within the scope of the license of the professional performing the service.
c. Rendered while coverage under this Plan is in force.
d. Not experimental or investigational or otherwise excluded or limited by this Plan, or by any amendment or rider thereto.
e. Authorized in advance by the Contract Administrator if such preauthorization is required in this Plan Document.

**Custodial Care** Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:
- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. hospital or skilled nursing facility) or at home.

**Day Treatment Patient** A patient receiving mental health or substance abuse care on an individual or group basis for more than two hours but less than 24 hours per day in either a hospital, rural mental health center, substance abuse treatment facility, or community health center. This type of care is also called partial hospitalization.

**Deductible** The amount you are required to pay each Benefit Year toward the Maximum Allowed Amount for certain covered services before this Plan provides benefits.

**Dental Service** Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the laminar dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

**Dependent** The eligible employee's lawful spouse, unmarried children and others as outlined in the Eligibility, Termination and Continuation of Coverage section of this Plan Document.

**Diagnostic Service** A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

**Discount** Favorable rates or discounts the Contract Administrator has negotiated with hospitals and other providers. Plan Participants benefit from these rates or discounts since they are applied prior to calculating your share of costs. Discounted charges reduce the expenses paid by the Plan which helps to lower the costs.

**Domiciliary Care** Care provided in a residential institution, treatment center, halfway house, or school because a Plan Participant's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

**Durable Medical Equipment** Equipment that meets all of the following criteria:

- Can withstand repeated use;
- Is used only to serve a medical purpose;
- Is appropriate for use in the patient's home;
- Is not useful in the absence of illness, injury, or disease; and
- Is prescribed by a physician.

Durable medical equipment does not include fixtures installed in your home or installed on your real estate.

**Early Intervention Services** Services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

**Effective Date** The first day of coverage with the Plan.

**Emergency Medical Condition** A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:
- That there is inadequate time to safely transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or unborn child.

**Emergency Service** Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:
- Placing the Plan Participant's physical and/or mental health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

Examples of illnesses or conditions that may require emergency services include, but are not limited to: heart attack, stroke or severe hypertensive reaction, coma, blood or food poisoning, severe bleeding, shock, obstruction (airway, gastrointestinal or urinary tract), and allergic or acute reactions to drugs.

**Enrollment Period** The period during which you are eligible to enroll in the Plan.

**ERISA** The Employee Retirement Income Security Act of 1974, as amended.

**Expense** A charge a person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

**Experimental or Investigational** Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Plan determines in its sole discretion to be experimental or investigational.

The Plan will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

(a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

1. cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or
2. has been determined by the FDA to be contraindicated for the specific use; or
3. is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or
4. is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or
5. is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by the Plan. In determining whether a service is experimental or investigational, the Plan will consider the information described in subsection (c) and assess the following:

1. whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;
2. whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
3. whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
4. whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information considered or evaluated by the Plan to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:

1. published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
2. evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
3. documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
4. documents of an IRB or other similar body performing substantially the same function; or
5. consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
6. the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
7. medical records; or
8. the opinions of consulting providers and other experts in the field.

(d) The Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational.

**Family Planning** An agency that meets both of the following requirements:

- Is a delegated family planning agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets the Contract Administrator's standards for participation.

**Freestanding Imaging Center** An institution that meets both of the following requirements:

- Licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center; and

- Meets the Contract Administrator's standards for participation.

**Freestanding Surgical Facility** An institution that meets all of the following requirements:
- Has a medical staff of physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis;
- Is licensed in accordance with the law of the appropriate legally authorized agency; and
- Meets the Contract Administrator's standards for participation.

**Full-Time** Individuals regularly employed by the Participating Trust Employer in the usual course of business and working at least the number of hours per week established by the Participating Trust Employer as the normal work week, but in no event less than the number of hours shown in the section on Eligibility, Termination, and Continuation of Coverage.

**Home Health** An institution that meets both of the following requirements:
- Licensed as a home health agency; and
- Meets the Contract Administrator's standards for participation.

**Hospice** A facility that meets both of the following requirements:
- Licensed as a hospice; and
- Meets the Contract Administrator's standards for participation.

**Hospice Care** Services that furnish pain relief, symptom management, and support to terminally ill patients and their families.

**Hospital** An institution that is duly licensed by the state of Maine as an acute care, rehabilitation or psychiatric hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

**Illness** Sickness or disease that causes loss covered by the Plan. Such loss must commence while the Plan Participant whose illness is the basis of a claim is covered under the Plan, unless otherwise indicated herein. Losses incurred by a Plan Participant because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any illness.

**Inborn Error of Metabolism** A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

**Independent Laboratory** An institution that meets both of the following requirements:
- Licensed as an independent medical laboratory; and
- Meets the Contract Administrator's standards for participation.

**Infertility** The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate independent professional associations.

**Inpatient** A registered bed patient who occupies a bed in a hospital, skilled nursing facility, or residential treatment facility. A patient who is kept overnight in a hospital solely for observation is not considered a registered inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an outpatient.

**Inpatient Stay** One period of continuous, inpatient confinement. An inpatient stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care hospital to another acute care hospital as an inpatient when medically necessary is part of the same stay.

**Late Enrollee** An employee or a dependent family member for whom an application for enrollment under the Plan is submitted following the initial enrollment period provided under the terms of the Plan; an employee or dependent family member for whom an application for enrollment is submitted after 31 days following any of the qualifying life events described in the Eligibility, Termination, and Continuation of Coverage section of this Plan Document, or an employee or dependent family member for whom no application for enrollment is submitted during the annual enrollment period. A late enrollee may only submit an application during the next annual enrollment period..

**Maintenance Prescription Drug** A Prescription Drug that is used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes.

**Maintenance Therapy** Any treatment, service, or therapy that preserves the Plan Participant's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

**Maximum Allowed Amount** The maximum amount that we will allow for Covered Services you receive. For more information, see the "Benefit Determinations, Payments and Appeals" section.

**Medicaid/Maine Care** Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

**Medically Necessary Health Care** "Medically necessary health care" means health care services or products provided to a Plan Participant for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of best practices in the medical profession; and
- Not primarily for the convenience of the Plan Participant or physician or other health care practitioner.

The Plan Administrator reserves the right to determine medical necessity and may consult with an appropriate medical consultant or review group.

**Medicare** Title XVIII of the United States Social Security Act, Medical Care for the Aged and Disabled.

**Mental Health Service** A service to treat any disorder that affects the mind or behavior regardless of origin.

**Morbid Obesity** A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

**Network Pharmacy** Any Pharmacy, located within the United States, acceptable as a Participating Pharmacy by Anthem to provide Covered Drugs to Members under the terms and conditions of this Certificate. Also referred to as "Participating Pharmacy".

**Network Specialty Pharmacy** Any appropriately licensed Pharmacy located within the United States which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render Specialty Drug services and certain administrative functions.

**Network Providers and Professionals** Health care providers and professionals that have a written agreement with the Contract Administrator to furnish health care services under this Plan. Also referred to as participating providers and professionals.

**Non-Network Pharmacy** Any appropriately licensed Pharmacy, located within the United States that is not a Participating Pharmacy under the terms and conditions of this Certificate. Also referred to as "Non-Participating Pharmacy".

**Non-Network Providers and Professionals** Health care providers and professionals that do not have a written agreement with the Contract Administrator to furnish health care services under this Plan. Also referred to as non-participating providers and professionals. Providers and professionals who have not contracted or affiliated with the Contract Administrator's designated Subcontractor(s) for the services they perform under this Plan are also considered non-network providers.

**Orthognathic Surgery** A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

**Orthotic Device** A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

**Outpatient** A patient who receives services at a provider and who is not a registered inpatient or a day treatment patient. A patient who is kept overnight in a hospital solely for observation is considered an outpatient. This is true even though the patient uses a bed.

**Participating Trust Employer** An employer participating in and making the required contributions toward the cost of the Maine Automobile Dealers Association Insurance Trust.

**Pharmacy** Any retail establishment operating under a license and in which a registered pharmacist dispenses prescription drugs.

**Pharmacy and Therapeutics Committee** Anthem's national committee made up of Physicians and other experts in medicine and Pharmacy.

**Physician** See definition of Professional.

**Plan or the Plan** The Maine Automobile Dealers Association Insurance Trust Group Medical Plan.

**Plan Administrator** The Maine Automobile Dealers Association, Inc.

**Plan Document** The documents that describe the benefits available to Plan Participants under this Plan.

**Plan Participant** A covered employee or the employee's eligible dependents who meet the eligibility requirements described in the Eligibility, Termination and Continuation of Coverage section of this Plan

Document. A dependent child may not be a covered dependent of more than one employee, and an employee may not be another employee's covered dependent.

**Prescription Drugs** A narcotic or medicine approved by the federal Food and Drug Administration (FDA) for use outside of a hospital dispensed under a physician's written order. Prescription drugs are: required by state law to be dispensed only with a prescription; required by law to display the notice, "Caution: Federal law prohibits dispensing without a prescription"; any other drug the Contract Administrator may approve through their drug approval process.

**Professional** An independently billing, licensed health care specialist acting within the scope of his or her license. Only the following professionals are eligible for payment under this contract:

Physicians

- Doctor of Medicine
- Doctor of Osteopathy

Other Professionals

- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Counselors
- Licensed Marriage and Family Therapist
- Licensed Pastoral Counselor
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Registered Nurse
- Licensed Practical Nurse
- Certified Nurse Midwife
- Ambulance Services
- Other professionals that have written network agreements with the Contract Administrator
- Other professionals as required by law.

**Prostheses** Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

**Provider** A licensed health care institution, facility, or agency. Only the following providers are eligible for payment under this contract:

- Acute-care hospitals
- Skilled nursing facilities
- Rural health centers
- Home health agencies
- Ambulatory surgery centers
- Hospices
- Community mental health centers
- Substance abuse treatment centers
- Licensed pharmacies
- Acute care psychiatric and rehabilitation hospitals
- Independent laboratories

- Freestanding imaging centers
- Family planning agencies
- Durable medical equipment providers
- Home infusion providers
- Other providers that have written contracts with the Contract Administrator
- Other providers, as required by law.

**Radiation Therapy** The use of high energy penetrating rays to treat an illness or disease.

**Reconstructive Procedures** Procedures performed on structures of the body to improve or restore bodily function or to correct deformity when there is functional impairment resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

**Routine Newborn Care** Care of newborn children, including nursery room and board, miscellaneous expenses, services of a pediatrician for attendance at a caesarean section, physical examination for a newborn while hospital confined and circumcision of a newborn.

**Rural Health Center** An institution that meets both of the following requirements:
- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets the Contract Administrator's standards for participation.

**Sitter/Companion** A person who provides short-term supervision of hospice patients during the temporary absence of family members.

**Skilled Nursing Facility (SNF)** An institution that meets all of the following requirements:
- Licensed as a skilled nursing facility;
- Accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients;
- Engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board;
- Provides 24-hour-per-day nursing care by or under the supervision of a registered nurse (RN);
- Maintains a daily medical record for each patient;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets the Contract Administrator's standards for participation.

**Specialist Service** A service by a professional practicing in specialty areas such as cardiology, neurology, surgery, and other specialties.

**Specialty Drug** The term "Specialty Drug" means prescription legend drugs which:
- are approved to treat limited patient populations, indications or conditions;
- are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- have limited availability, special dispensing and delivery requirements, and/or require additional patient support- any or all of which make the Drug difficult to obtain through traditional pharmacies.

**Subcontractor** An organization or entity that provides particular services in specialized areas of expertise. Examples of subcontractors include, but are not limited to, prescription drugs, mental health/ behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on behalf of the Contract Administrator.

**Substance Abuse** The misuse, excessive use, or improper use of alcohol or drugs to the extent that such use contributes to physical, mental, or social dysfunction, regardless of origin.

**Substance Abuse Treatment Facility** A residential or nonresidential institution that meets all of the following requirements:

- Licensed or certified as a substance abuse treatment facility;
- Provides care to one or more patients for alcoholism and/or drug dependency;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets the Contract Administrator's standards for participation.

**Surgical Assistant** A physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified professionals as permitted by law and recognized by the Contract Administrator, who actively assists the operating surgeon in performing a covered surgical service.

**Surgical Service** A service performed by a professional acting within the scope of his or her license that is:

- A generally accepted operative and cutting procedure;
- An endoscopic examination or other invasive procedure using specialized instruments; or
- The correction of fractures and dislocations.

**Telemedicine** The use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine, or e-mail.

**Terminal Illness** A terminal illness exists if a person becomes ill with a prognosis of 12 months or less to live, as diagnosed by a physician.

**Tier Listing** The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

**Treatment of Autism Spectrum Disorders** The following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

**Utilization Management** The process used to determine the medical necessity, appropriateness, efficacy or efficiency of health care services. Techniques include inpatient admission review, continued inpatient stay review, discharge planning, post admission review and case management.

**Waiting Period** The period required before enrollment is allowed.

**Walk-In Center / Retail Health Clinic** The terms Walk-In Center and Retail Health Clinic mean a free-standing center providing episodic health services without appointments for diagnosis; care; and treatment.

**You or Your** The employee and all dependents covered under the Plan.

# Section Eight
# ERISA Rights

You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine without charge at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the United States Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, you can take steps to enforce the rights explained above. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a daily penalty fee until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits and Security Administration, U.S. Department of Labor, J.F. Kennedy Federal Building, Room 575, Boston, MA 02203 (617-565-9600) or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

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